

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2 Welmesley St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Winfield Adams</u> First Middle Last		4. DATE OF DEATH <u>Mar 15</u> 19 <u>55</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1881</u>
9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wm Adams</u>		14. MOTHER'S MAIDEN NAME <u>Caroline (Last name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Donna Ingram</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-54</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of Deceased: JOHN W. BROWN

2. Sex: Male

3. Age: 45

4. Date of Death: 10/15/1918

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Signature of Medical Examiner: [Signature]

8. Date of Certificate: 10/15/1918

CERTIFICATE OF DEATH

03219

Reg. Dist. No.

3257

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 Bryn Mawr Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>6 Glen Echo</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julian</u> Middle <u>Neale</u> Last <u>Albin</u>				4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Charles H. Albin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Upright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1943-1945</u>				16. SOCIAL SECURITY NO. <u>519-05-5910</u>		17. INFORMANT <u>Elsie M. Albin</u> Address <u>6 Glen Echo Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>At. intracerebral hemorrhage & cerebral edema</u> <u>1959</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>At. parietal-occipital tumor (Glioblastoma multiforme)</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	Month <u>19</u>	Day <u>19</u>	Year <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 15</u> , 19 <u>59</u> , to <u>Mar 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 1</u> , 19 <u>59</u> , and that death occurred at <u>10:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1726 M St. NW Wash DC</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Jonathan M. Williams</u> M.D.				PHYSICIAN'S NAME (Type) <u>Jonathan M. Williams</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda 14, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3258

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 214 East Main Street			
3. NAME OF DECEASED (Type or print) First Wheeler Middle Martin Last Anderson, Jr.				4. DATE OF DEATH Month March Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 21, 1955	
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 0 Days 13		IF UNDER 24 HRS. Hours Min. 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maine				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wheeler M. Anderson, Sr.				14. MOTHER'S MAIDEN NAME Mary M. Marks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Enterocolitis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Months Hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 13, 19 59 , to March 5, 19 59 , that I last saw the deceased alive on March 5, 19 59 , and that death occurred at 1:55 a. m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-5-59 NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE Leonard Garren M.D.							
PHYSICIAN'S NAME (Type) Leonard Garren, M. D.							
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF 3/7/59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Williamston N. CAROLINA	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, MD				24a. REC'D BY REGISTRAR MAR 9 59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

CERTIFICATE OF DEATH

1925

Name of Deceased: John Doe

Age: 45 Sex: Male

Place of Birth: John Doe, Maryland

Residence: John Doe, Maryland

Date of Death: January 15, 1925

Time of Death: 10:00 AM

Place of Death: John Doe, Maryland

Cause of Death: Acute myocardial infarction

Manner of Death: Natural

Signature of Physician: John Doe, M.D.

Signature of Registrar: John Doe, Registrar

Signature of Coroner: John Doe, Coroner

Signature of Burial Officer: John Doe, Burial Officer

Signature of Undertaker: John Doe, Undertaker

Signature of Minister: John Doe, Minister

Signature of Priest: John Doe, Priest

Signature of Rabbi: John Doe, Rabbi

Signature of Imam: John Doe, Imam

3259

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown 03X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) Kensington Gardens				d. STREET ADDRESS 357 Main Street			
3. NAME OF DECEASED (Type or print) Eva Bell Barnsley				4. DATE OF DEATH March 15 1959			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1. 1874	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR 0 Months 14 Days		11. IF UNDER 24 HRS. 0 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Olney, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Silas A. Bell			
14. MOTHER'S MAIDEN NAME Emma Rebecca Cashell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None			
16. SOCIAL SECURITY NO. None				17. INFORMANT 949 Palmer Road Lewis W. Barnsley-Bronxville, N.Y. -Son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Coronary Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from November 1958 to March 1959 , that I last saw the deceased alive on March 7, 1959 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Q. Ekman M.D.				ADDRESS (Street, city or town, state) 5707 Wisconsin Ave, Beltsville, Maryland			
PHYSICIAN'S NAME (Type) Donald Q. Ekman				DATE SIGNED 3/15/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-59		22c. NAME OF CEMETERY OR CREMATORY St. John's Epis. Ch. Cem.		22d. LOCATION (City, town, or county) Olney, Maryland (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda 14, Md.		24a. REC'D BY REGISTRAR MAR 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03222

Reg. Dist. No.

3260

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY d. STREET ADDRESS OLNEY MANOR e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN MURPHY BEANE		4. DATE OF DEATH Month MARCH Day 5 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/93
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN BEANE		14. MOTHER'S MAIDEN NAME MARY LOUIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulonephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1-3 wks. years.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 27 , 19 59 , to March 6 , 19 59 , that I last saw the deceased alive on March 5 , 19 59 , and that death occurred at 11:47 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) OLNEY, MARYLAND DATE SIGNED 3-6-59 ACTUAL SIGNATURE R.A. Yates M.D. PHYSICIAN'S NAME (Type) R.A. YATES, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 9	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR DATE MAR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Time of death: _____
8. Cause of death: _____
9. Place of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of filing: _____

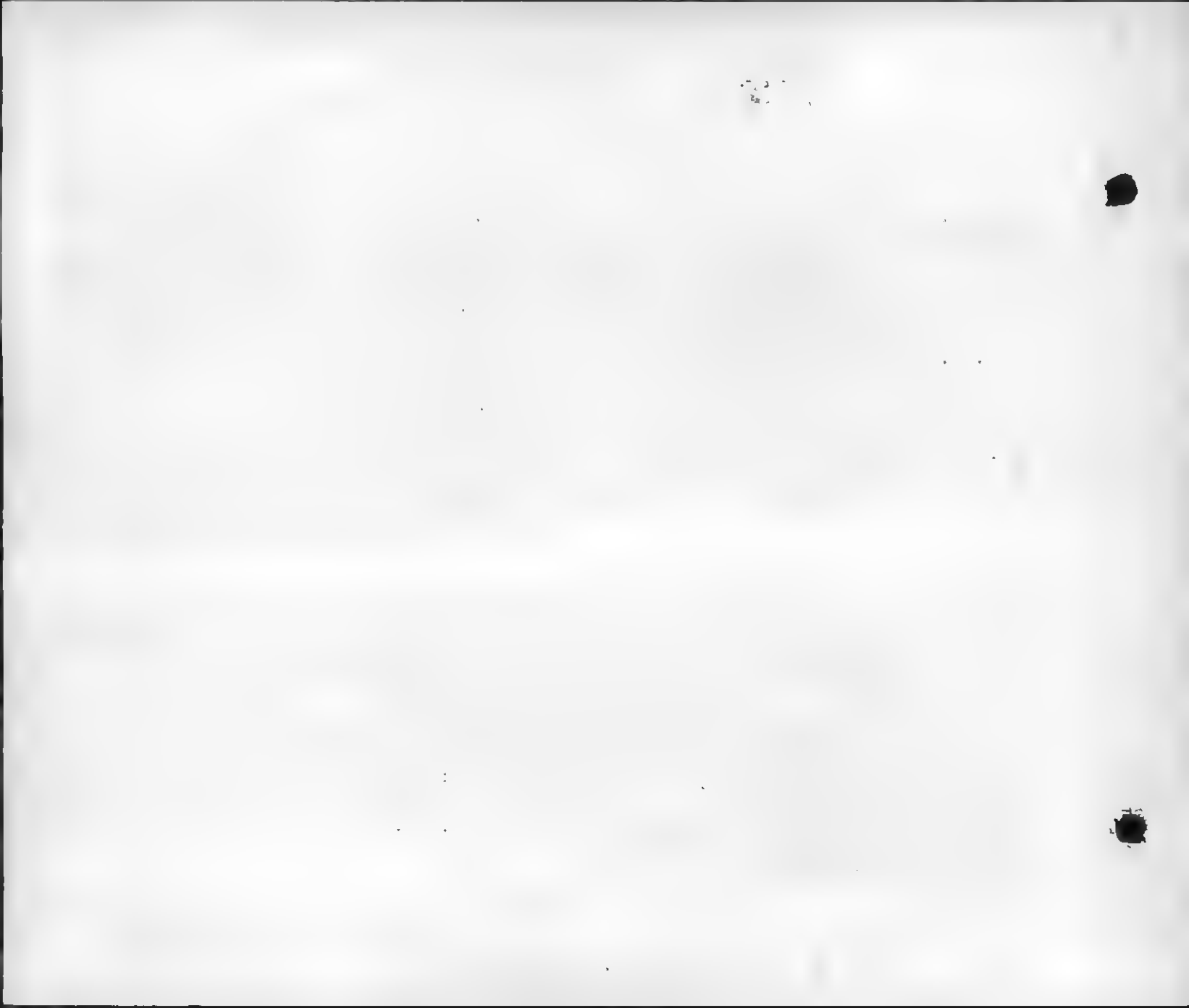
3261
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 17 days				2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admiss on) a. STATE Virginia b. COUNTY Quantico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Qtrs. 146, Marine Corps Schools d. STREET ADDRESS Qtrs. 146, Marine Corps Schools e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Wendell Harvey BEST				4. DATE OF DEATH Month Day Year March 21 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-18	
9. AGE (In years last birthday) 40 yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Idaho				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harold BEST				14. MOTHER'S MAIDEN NAME Rachael MC CORMICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO. 7-22-39 to DON 529-07-8950		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 431X Myocarditis, acute, cause unknown DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 mo.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4 19 59 , to March 21 19 59 , that I last saw the deceased alive on March 21 19 59 , and that death occurred at 1:12P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED F. H. O'Connell M.D. U. S. Naval Hospital, NMMC Bethesda, Md.							
ACTUAL SIGNATURE F. H. O'Connell							
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT MC USN Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipments 3-23-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Salt Lake City Cemetery		22d. LOCATION (City town, or county) (State) Salt Lake City Utah	
23. FUNERAL DIRECTOR'S SIGNATURE Adams ADDRESS Adams Funeral Home, 4748 Wisc. Ave. NW, Wash. DC				24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Idaho b. COUNTY Kootenai c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coeur d'Alene d. STREET ADDRESS 506 LaCrosse e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Donald Earl BLACK		4. DATE DEATH Month Day Year March 25 1959	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-56
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Lee BLACK		14. MOTHER'S MAIDEN NAME Carrie B. MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Interventricular Septal Defect with Pulmonary Hypertension) 754. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs.			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7 , 1959, to March 25 , 1959, that I last saw the deceased alive on March 25 , 1959, and that death occurred at 5:55 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 3-26-59			
ACTUAL SIGNATURE J. E. Mc Cleathur		M.D. U. S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) J. E. MC CLEATHUR, CDR, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 3-28-59	22b. DATE THEREOF 3-28-59	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Coeur d'Alene Idaho
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. H...

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



3263
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Patuxent River / X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ d. STREET ADDRESS MEMO 711C e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle BLACKA Last BLACKA		4. DATE OF DEATH Month March Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-59
9. AGE (In years last birthday) yrs. 8 27		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Patuxent River, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lowell W. BLACKA		14. MOTHER'S MAIDEN NAME Marilyn MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration & fatal infection during birth DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1959 , to March 7, 1959 , that I last saw the deceased alive on March 7, 1959 , and that death occurred at 3:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 3-8-59			
ACTUAL SIGNATURE Harry L. Walton M.D.		PHYSICIAN'S NAME (Type) Harry L. WALTON, LT, MC, USN Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Shipment 3-11-59	22b. DATE THEREOF 3-11-59	22c. NAME OF CEMETERY OR CREMATORY Sugar Creek Cemetery	22d. LOCATION (City, town, or county) (State) Sugar Creek Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home ADDRESS 4748 Wisc. Ave., NW, Wash., DC		24a. REC'D BY REGISTRAR MAR 12 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3264

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural), c. LENGTH OF STAY IN 1b 4hrs. 32min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. NAVAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 7 Armor Green, S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Theresa Marie BLECLIC				4. DATE OF DEATH Month March Day 10 Year 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-59	
9. AGE (In years last birthday) yrs. 4		10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John P. Blecllic			
14. MOTHER'S MAIDEN NAME Grace Moore				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO None				17. INFORMANT (F) John P. Blecllic, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic maturity 27 weeks gestation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 4 hr 32 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1959 to March 10, 1959 , that I last saw the deceased alive on March 10, 1959 , and that death occurred at 3:30P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 3-11-59							
ACTUAL SIGNATURE D. and Harris M.D.				PHYSICIAN'S NAME (Type) David Harris, LT., MC, USN Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS R.A. Pumphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

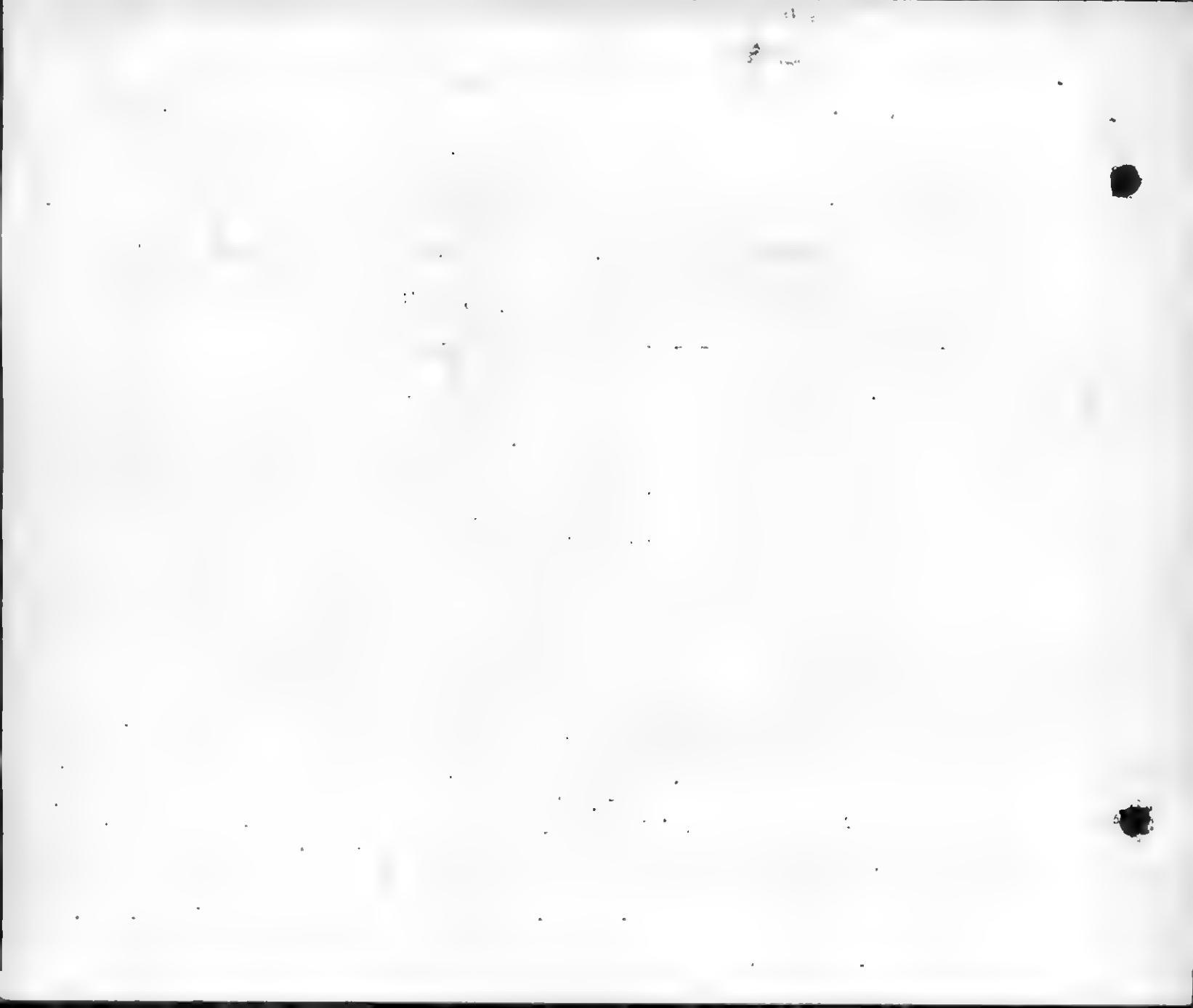
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and if any event within 24 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113225

3265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6425 - Broad Street</u>		e. STREET ADDRESS <u>6425 - Broad Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES WILLIAM BRANDENBURG</u>		4. DATE OF DEATH Month Day Year <u>MARCH 21, 1959</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 6, 1871</u>
9. AGE (In years last birthday) yrs. <u>87</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>7 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>ORANGEBURG, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS PERRY BRANDENBURG</u>		14. MOTHER'S MAIDEN NAME <u>KELLER ELIZA CAROLINE BRANDENBURG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JAMES W. BRANDENBURG JR., BROOKMONT, MD.</u>		Address <u>6425 BROAD ST. BROOKMONT, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adrenocortical insufficiency</u> DUE TO <u>glands</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>See above</u> (c) <u>See above</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1951</u> , 19____, to <u>Mar. 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 20</u> , 19 <u>59</u> , and that death occurred at <u>4 2</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hugh O. House</u> M.D. <u>1835 Ego St. N.W. Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MATTHEWS CATH. CH. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ORANGEBURG, SOUTH CAROLINA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hyson</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	
ADDRESS <u>Wash. St. B. 1306-N St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03229

Reg. Dist. No.

3223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN TB <u>9 days</u>		d. STREET ADDRESS <u>719 Kennebec Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Brenda</u> Middle <u>Lou</u> Last <u>Bretz</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-41</u>
9. AGE (In years last birthday) <u>18</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Russell Bretz</u>		14. MOTHER'S MAIDEN NAME <u>Andra Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Chant</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Convulsions</u> <u>1592 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Epinephrine Epilepsy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>Month (2)</u> <u>Year (12)</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1958, to <u>March 8</u> , 1959, that I last saw the deceased alive on <u>March 8</u> , 1959, and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hume M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>NEEDS RD. JAKES G. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>254-6001 ST. NW.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3266

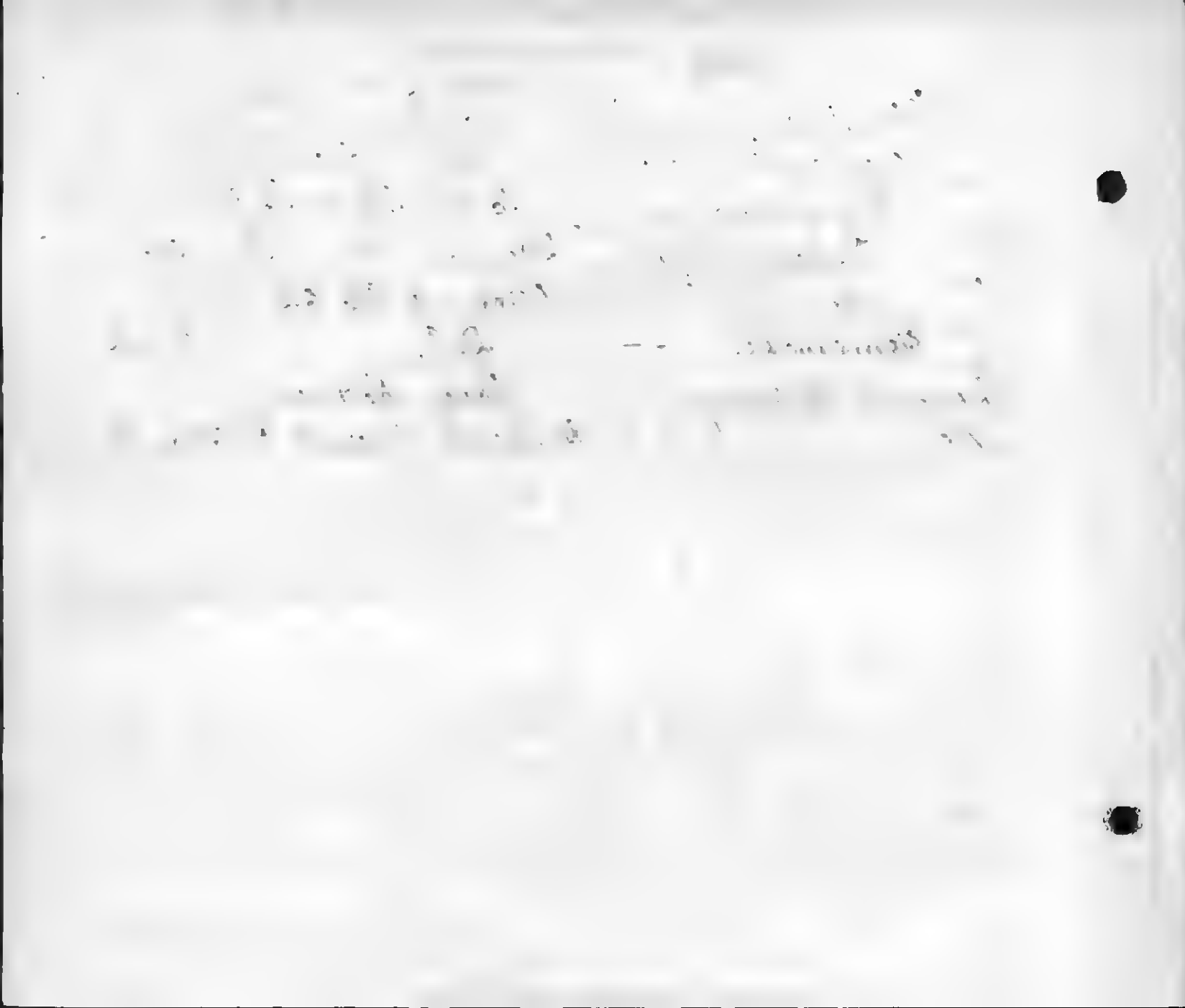
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1629 33rd St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Eileen</u> Middle <u>M.</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 10, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Money</u>		14. MOTHER'S MAIDEN NAME <u>Nora Kettner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Husband Everett R. Brown</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> <u>230 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of an aneurysm of the anterior communicating arteries, only by the circle of Willis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> to <u>3/26</u> <u>1959</u> , that I last saw the deceased alive on <u>3/26</u> <u>1959</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. W. T. E. DeLawter</u>		ADDRESS (Street, city or town, state) <u>8025 ARDEN RD</u>	
PHYSICIAN'S NAME (Type) <u>Dr. W. T. E. DeLawter, M.D.</u>		DATE SIGNED <u>3/26/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/30/59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chry Chase Funeral Home, Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
ADDRESS <u>5703</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3267

CERTIFICATE OF DEATH

Reg. Dist. No.

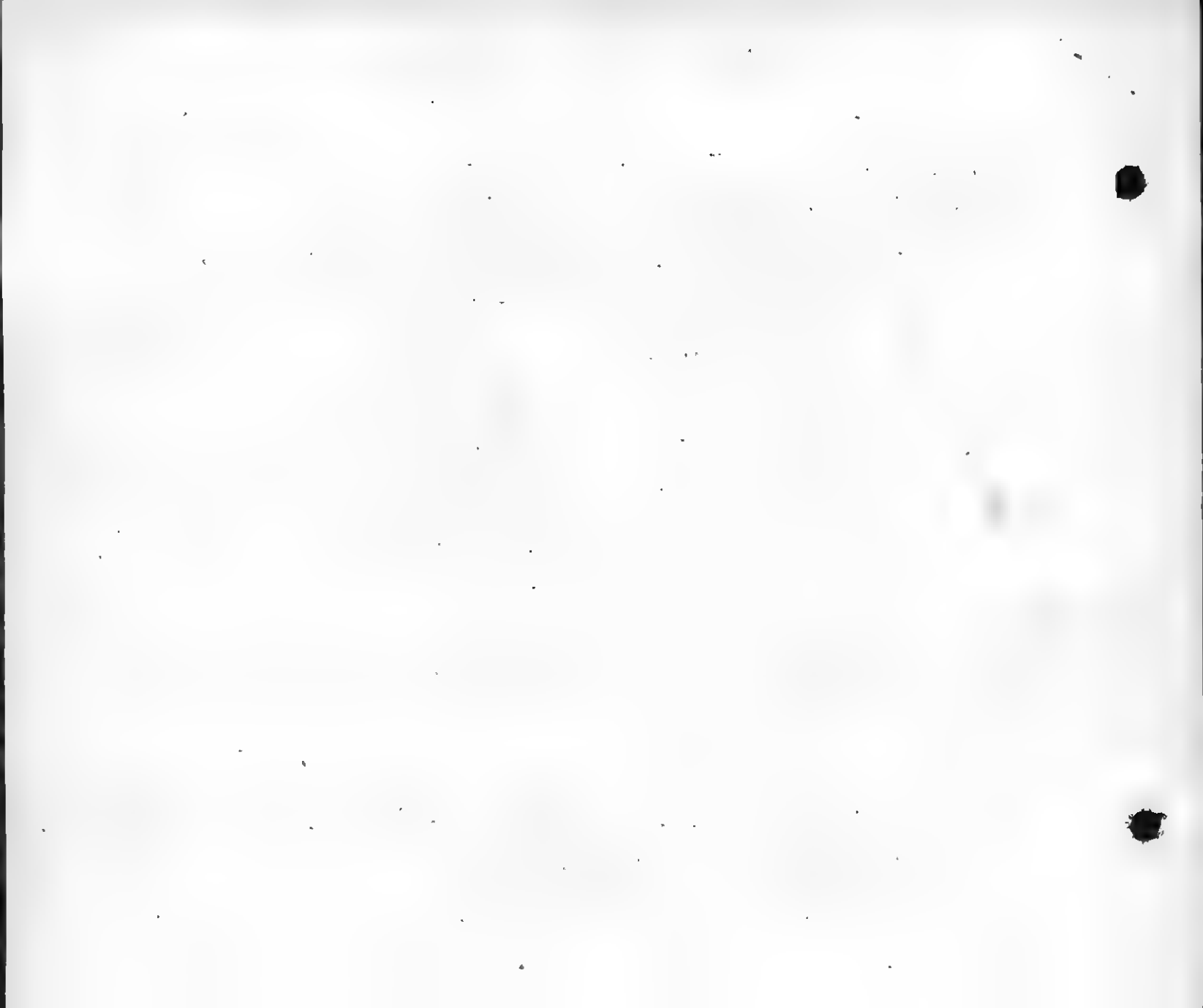
03231

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville c. LENGTH OF STAY IN lb 5 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm'ssion) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9303 Jesup Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL J. BROWN First Middle Last		4. DATE OF DEATH March 22, 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1894
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR 5 Months 0 Days	11. IF UNDER 24 HRS 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME John Hanson	
14. MOTHER'S MAIDEN NAME Elsie Swenson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Helen H. White-Item # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 4 yrs Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/1/1954 to 3/22/1959 , that I last saw the deceased alive on 3/22/1957 , and that death occurred at 2:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 3/22/59	
PHYSICIAN'S NAME (Type) Stephen Jones		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify).	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Bur-Transit	3/24/59	Green Wood Cemetery	Brooklyn, New York
23. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey		ADDRESS Bethesda, Maryland	24a. REC'D BY REGISTRAR MAR 24 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 and befiled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 9, Film G240, 3/23/59 3268 CERTIFICATE OF DEATH

03232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Webster Martin Brown</u>				4. DATE OF DEATH Month Day Year <u>March 15 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1891</u>	9. AGE (In years last birthday) <u>68</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Milton Brown</u>				14. MOTHER'S MAIDEN NAME <u>Souder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Kathryn B. Douglas</u> Address <u>Rockville, Md. Crawford Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar. 13</u> , 19 <u>59</u> , to <u>Mar. 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar. 15</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo I. Donovan</u> M.D.				ADDRESS (Street, city or town, state) <u>8016 Old Georgetown Rd Bethesda, Md</u>		DATE SIGNED <u>3/15/59</u>	
PHYSICIAN'S NAME (Type) <u>LEO I. DONOVAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Mar 18 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Episcopal Church</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St NW</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3226

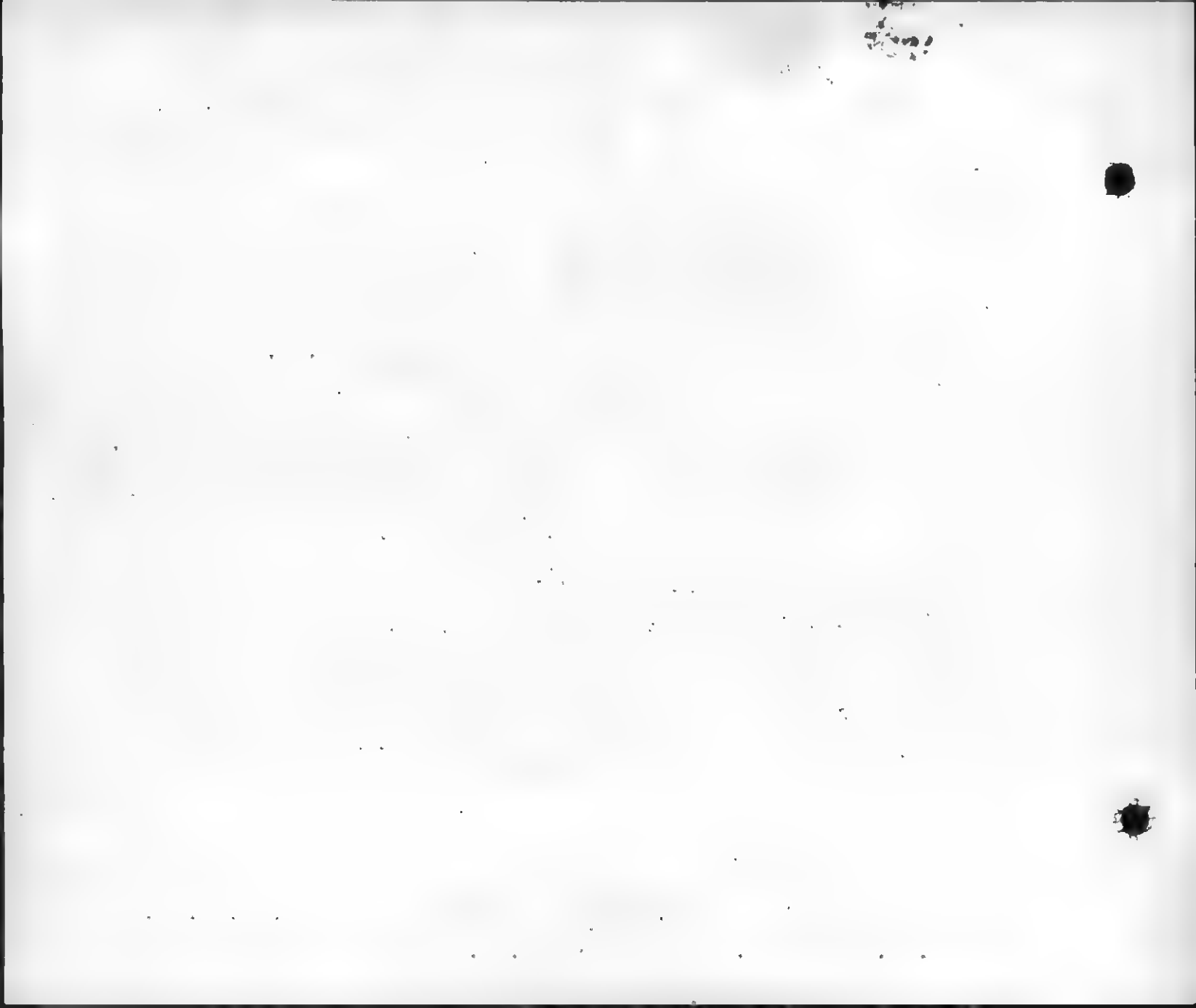
CERTIFICATE OF DEATH

Reg. Dist. No.

03233

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Haven Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Babette Middle Kraft Last Burkhart		4. DATE OF DEATH Month March Day 20 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 20 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? Housewife		13. FATHER'S NAME Adam Kraft	
14. MOTHER'S MAIDEN NAME Babette Sievers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		INFORMANT Home Records-7300 Baltimore Ave.	
17. ADDRESS Takoma Pk, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Acute cholecystitis DUE TO (c) Cholelithiasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Arteriosclerosis and hypertension	
19. INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month July Day 31 Year 1959 Hour a. m. 12:30 p. m. PM		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1959 to March 21, 1959 that I last saw the deceased alive on March 20, 1959 and that death occurred at 12:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Marie Page		DATE SIGNED 1150 Conn. St. Wash. D.C. 321	
PHYSICIAN'S NAME (Type) R. MARIE PAGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/23/59	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. REC'D BY REGISTRAR MAR 23 '59	
ADDRESS Washington, D. C.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



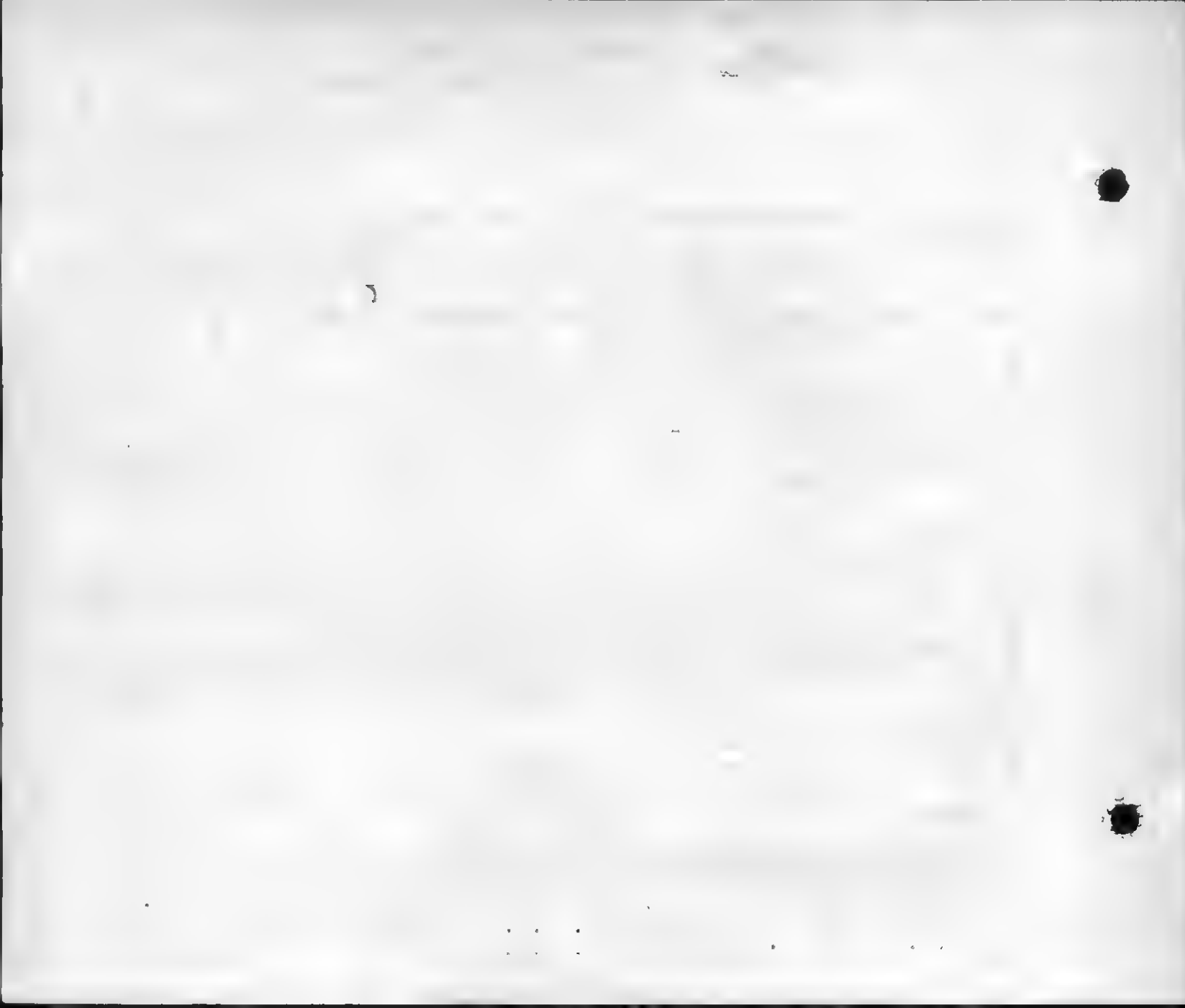
3269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 8</u> 4.			
f. STREET ADDRESS <u>5137 Nebraska Ave NW</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Laverne</u> First <u>Stephen</u> Middle <u>Byrne</u> Last				4. DATE OF DEATH <u>March</u> Month <u>31</u> Day <u>1959</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Linotype operator</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Alfred Byrne</u>				14. MOTHER'S MAIDEN NAME <u>Rosetta Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-46-055B</u>		17. INFORMANT <u>Ruby Hoodford Byrne (wife)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4:55 p.m.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia, hypostatic</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/21</u> , 1952, to <u>3/30</u> , 1959, that I last saw the deceased alive on <u>3/30</u> , 1959, and that death occurred at <u>10:50</u> a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>I. L. Marks</u>				ADDRESS (Street, city or town, state) <u>6306 Wisconsin Ave</u>			
PHYSICIAN'S NAME (Type) <u>I. L. MARKS, M.D.</u>				DATE SIGNED <u>3/31/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

3270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 8 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admiss on) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 4870 Chevy Chase Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva Couch		4. DATE OF DEATH Month March Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Thomas COUCH		14. MOTHER'S MAIDEN NAME Mary C. PARSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Rev. C. Randolph Mengers		Address 4200 Butterworth Pl., N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Internal carotid artery Thrombosis 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 5 , 19 59 , to 3-13 , 19 59 , that I last saw the deceased alive on 3-13 , 19 59 , and that death occurred at 9:20P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Galeraith		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) Robert S. GALERAITH LT MC USN		DATE SIGNED 3-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial-Shipment	3-17-59	Sleepy Hollow Cemetery	Tarrytown, New York
23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home		24. REC'D BY REGISTRAR AP	
Address 5103 Wisconsin Ave., N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Francis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3271 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9110 LeVelle Ct.</u>		1. STREET ADDRESS <u>9110 LeVelle Ct.</u>	
3. NAME OF DECEASED (Type or print) <u>Jefferson Callen</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Earl Robert Callen</u>		14. MOTHER'S MAIDEN NAME <u>Anita Blatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>9110 LeVelle Ct.</u>	
17. INFORMANT <u>Earl R. Callen</u>		Address <u>9110 LeVelle Ct. N. Cherry Chase Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of stomach contents</u> (c) <u>Upper Resp. Infection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-10-59</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar. 11, 1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden - Falls Church Va</u> 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Langworthy & Son - 3501 - 14th St. N.W.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>MAR 12 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Ife pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner Notified and jurisdiction waived
St. Clapp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

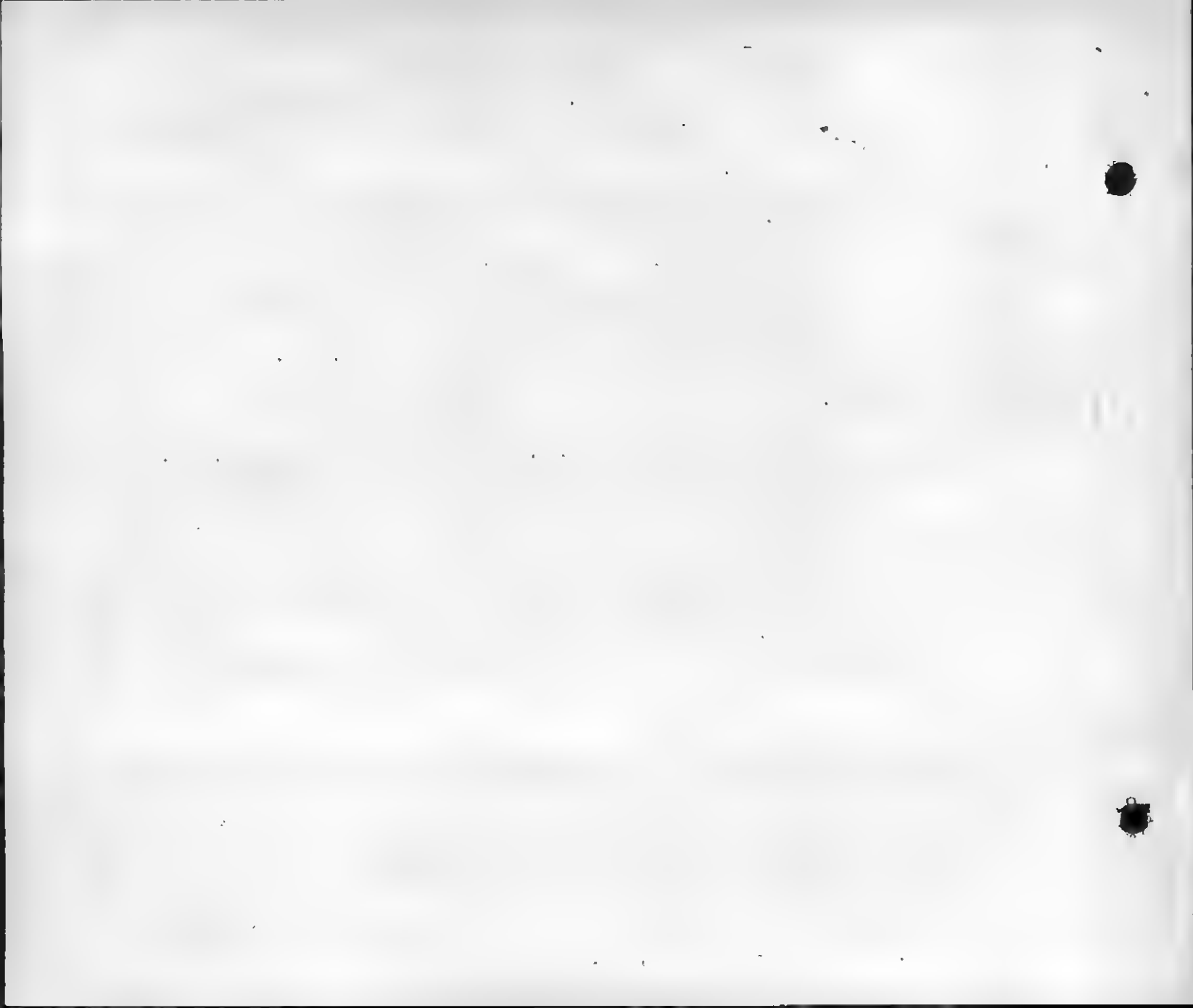
03237

3272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kensington Garden San. Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Garden San. 3000 McGomas Ave. Kensington Md.		d. STREET ADDRESS 3703 Thornapple Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary L. Canaga		4. DATE OF DEATH Month Day Year March 37 19 5 9	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1876
9 AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days 4 16	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (State or foreign country) Wheeling, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William G. Lewis		14. MOTHER'S MAIDEN NAME Samantha Chambers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT S.G. Stewart-Box 366 Stanton, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, massive, from intestinal tract DUE TO (b) Arteriosclerosis, severe, generalised DUE TO (c) Chronic hypertension, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia, left, old. INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 10 yrs + 10 yrs +			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 to 31.2.7. 1959 that I last saw the deceased alive on 3.16. 1959 and that death occurred at 7:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stewart Clapp M.D. 3921 Ingomar St. N.W. 3.27.59 PHYSICIAN'S NAME (Type) Stewart Clapp Wash 15 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3273

CERTIFICATE OF DEATH

03238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN TB 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS 218 Glenn St.	
3. NAME OF DECEASED (Type or print) Mrs. Louise Hagans Carvey		4. DATE OF DEATH Month March Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher—Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brandonville, West Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Clay Hagans		14. MOTHER'S MAIDEN NAME Mary Cavette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Asbury Methodist Home records As 1-2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) pneumonia DUE TO (c) Hypertensive cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 3-7 , 19 59 , to 3-15 , 19 59 , that I last saw the deceased alive on 3-15 , 19 59 , and that death occurred at 9:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sarah E. Glover M.D. 10128 Cedar Lane Kensington, Md. 3-15-59 PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 3-17-59 22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem. 22d. LOCATION (City, town, or county) (State) Fort Ashby, West Virginia 23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md. 24a. REC'D BY REGISTRAR MAR 17 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03239

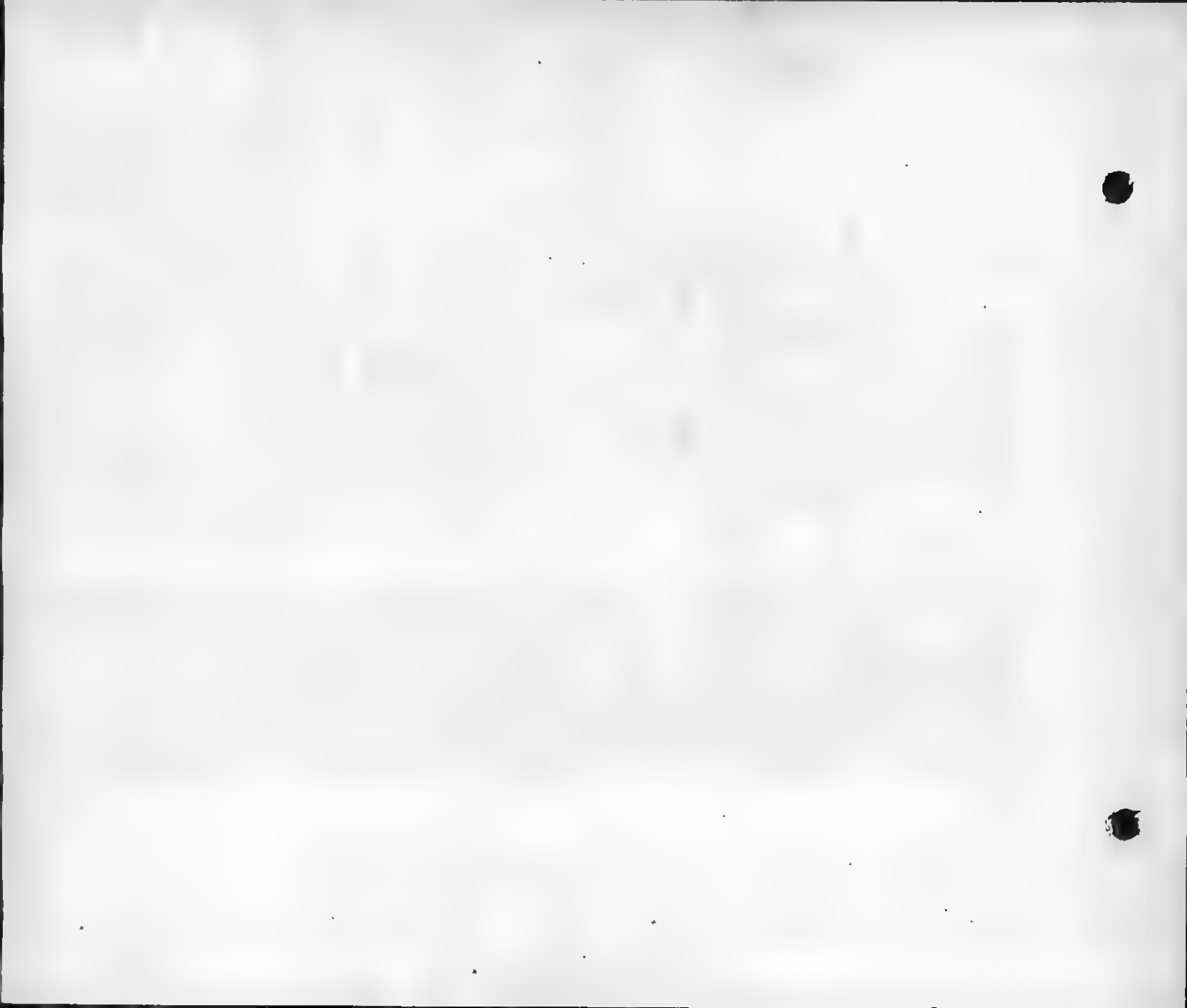
3274

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a STATE <u>md</u> b COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>unity</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Unity</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R-1 Brookville</u>		d STREET ADDRESS <u>R-1 Brookville</u>	
3. NAME OF DECEASED (Type or print) <u>Leater Lemar Charlton</u>		4 DATE OF DEATH <u>mar 23 1959</u>	
5. SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-6-1892</u>
9 AGE (in years last birthday) <u>66</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal dealer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Edmond W Charlton</u>	
14 MOTHER'S MAIDEN NAME <u>Clara Young</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16 SOCIAL SECURITY NO <u>Unknown</u>		17 INFORMANT <u>Clara Edna Charlton - Str 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>swollen</u> (c) <u>swollen</u>		INTERVAL BETWEEN ONSET AND DEATH <u>swollen</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>swollen</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>March 25</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		22d LOCATION (City, town, or county) (State) <u>Sunshine Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Ray C. Searver</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 26 '59</u>	
24b REGISTRAR'S SIGNATURE <u>Arthur B. Hantz</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 4-5-59 et

CERTIFICATE OF DEATH

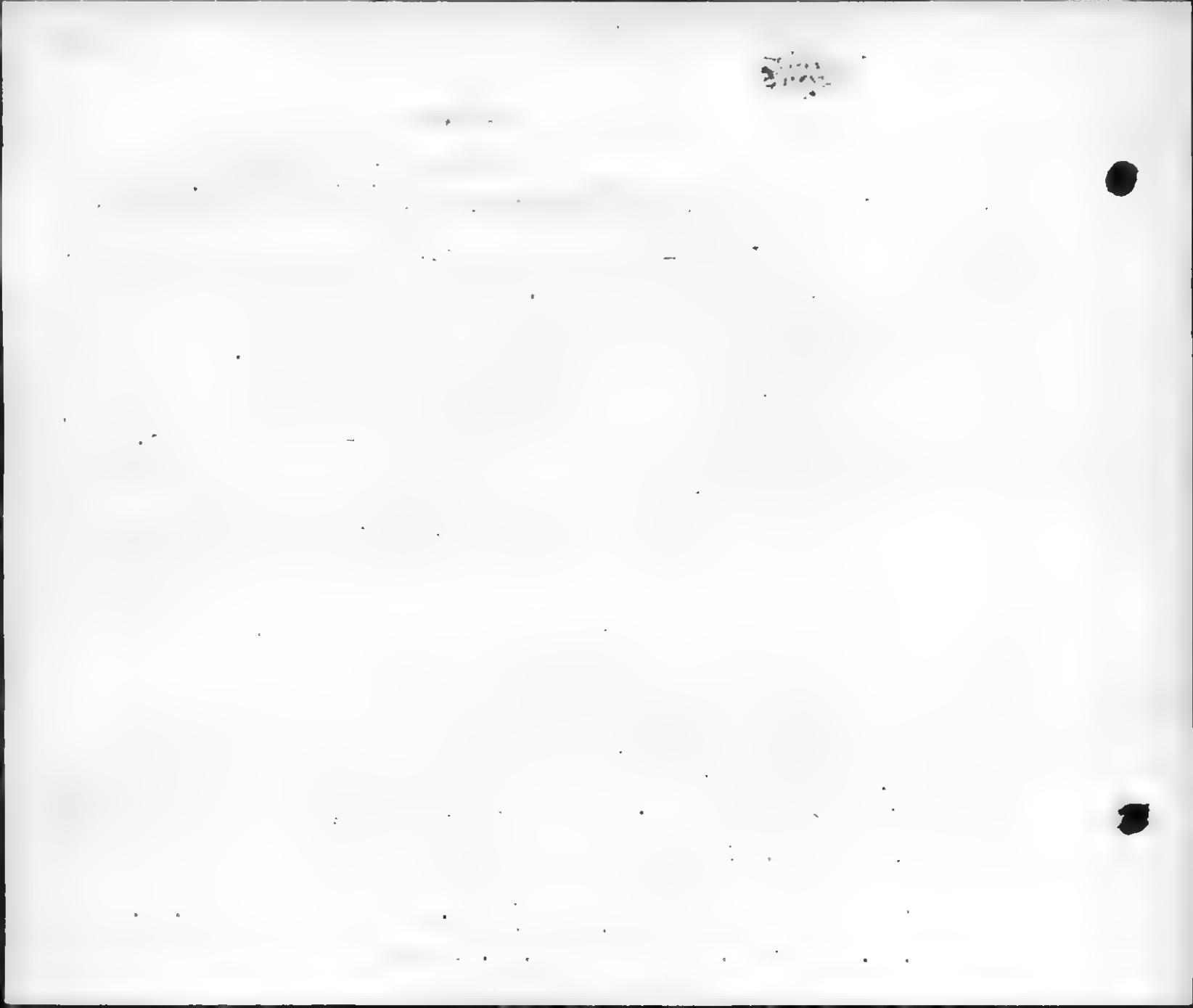
Reg. Dist. No.

03240

3227

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 165 St. N.W., Washington, D. C. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wakefield Nursing Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		2 USUAL RESIDENCE (Where deceased lived If institution-Residence before admission) b. COUNTY Maryland c. STREET ADDRESS 700 Hudson Ave. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Imogene Middle Bohrer Last Clarke		4. DATE OF DEATH Month 3 Day 30 Year 1959	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/28/1872
9 AGE (In years last birthday) 86		10. KIND OF BUSINESS OR INDUSTRY Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11 BIRTHPLACE (State or foreign country) Washington, D. C.	
12 CITIZEN OF WHAT COUNTRY? Washington, D. C.		13 FATHER'S NAME George Philip Bohrer	
14. MOTHER'S MAIDEN NAME Drucilla Hancock		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO		INFORMANT Address Takoma Park, MD Home Records -700 Hudson Ave.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sanility DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basilar intracerebral bleeding, etiology undetermined INTERVAL BETWEEN ONSET AND DEATH			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1958 to March 1959 , that I last saw the deceased alive on March 26, 1959 , and that death occurred at 8:00 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 217 University Blvd E DATE SIGNED 3-30-59 ACTUAL SIGNATURE Bernard A. Fitzgerald M.D. Silver Spring, Md. PHYSICIAN'S NAME (Type) Bernard A. Fitzgerald			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/59	
22c NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d LOCATION (City, town, or county) (State) Washington, D. C.	
23 FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR APR 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2-57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (Rural)</u>		c. LENGTH OF STAY IN 1b <u>3 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (Rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fields Rd</u>				d. STREET ADDRESS <u>Fields Rd</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Eliott Cohens</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-98</u>	
9. AGE (In years last birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>218-05-1584</u>		17. INFORMANT <u>Anna Cohens</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>3-2-59</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin L. Wolschert</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AR 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



3276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 172 days		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3622 Military Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle Cox Last Cox		4. DATE OF DEATH Month March Day 1, Year 1959		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1883		9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 5 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Corner				14. MOTHER'S MAIDEN NAME May Hiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia DUE TO 2.14.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Viral Hepatitis DUE TO (c) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 3 yr 12 mo	
						PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 10, 1958 , to March 1, 1959 , that I last saw the deceased alive on March 1, 1959 , and that death occurred at 3:48 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3-2-59 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Eugene H. Levin		M.D. The Clinical Center					
PHYSICIAN'S NAME (Type) Eugene H. Levin		M.D. The National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/4/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3277
MONTGOMERY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Iter 7, Film G241, 4/1/59
CERTIFICATE OF DEATH

03243

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring.		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 130 Ritchie Ave.,		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Henry W Cross		4 DATE OF DEATH Month March Day 31 Year 1959	
5 SEX male	6 COLOR OR RACE C	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 23, 1887
9 AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY School	11 BIRTHPLACE (State or foreign country) Washington, D. C.
12 CITIZEN OF WHAT COUNTRY? U. S. A.		13 FATHER'S NAME Robert Cross	
14 MOTHER'S MAIDEN NAME Alberta Tibbs		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hattie B. Cross Address 130 Ritchie Ave., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphatic Sarcoma DUE TO (b) Inguinal Glands Right first involved DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). Coronary Sclerosis; Mital Stenosis; Varicose Veins.			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that I attended the deceased from Feb 22, 1957 , to March 31, 1959 that I last saw the deceased alive on March 30, 1959 , and that death occurred at 5:39 A. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Webster Sewell		DATE SIGNED March 30, 1959	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.		ADDRESS Norbeck Rt. 1 Silver Spring, Md.	
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 4/4/59	22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial.	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23 FUNERAL DIRECTOR'S SIGNATURE Robert L. Suroden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



3278

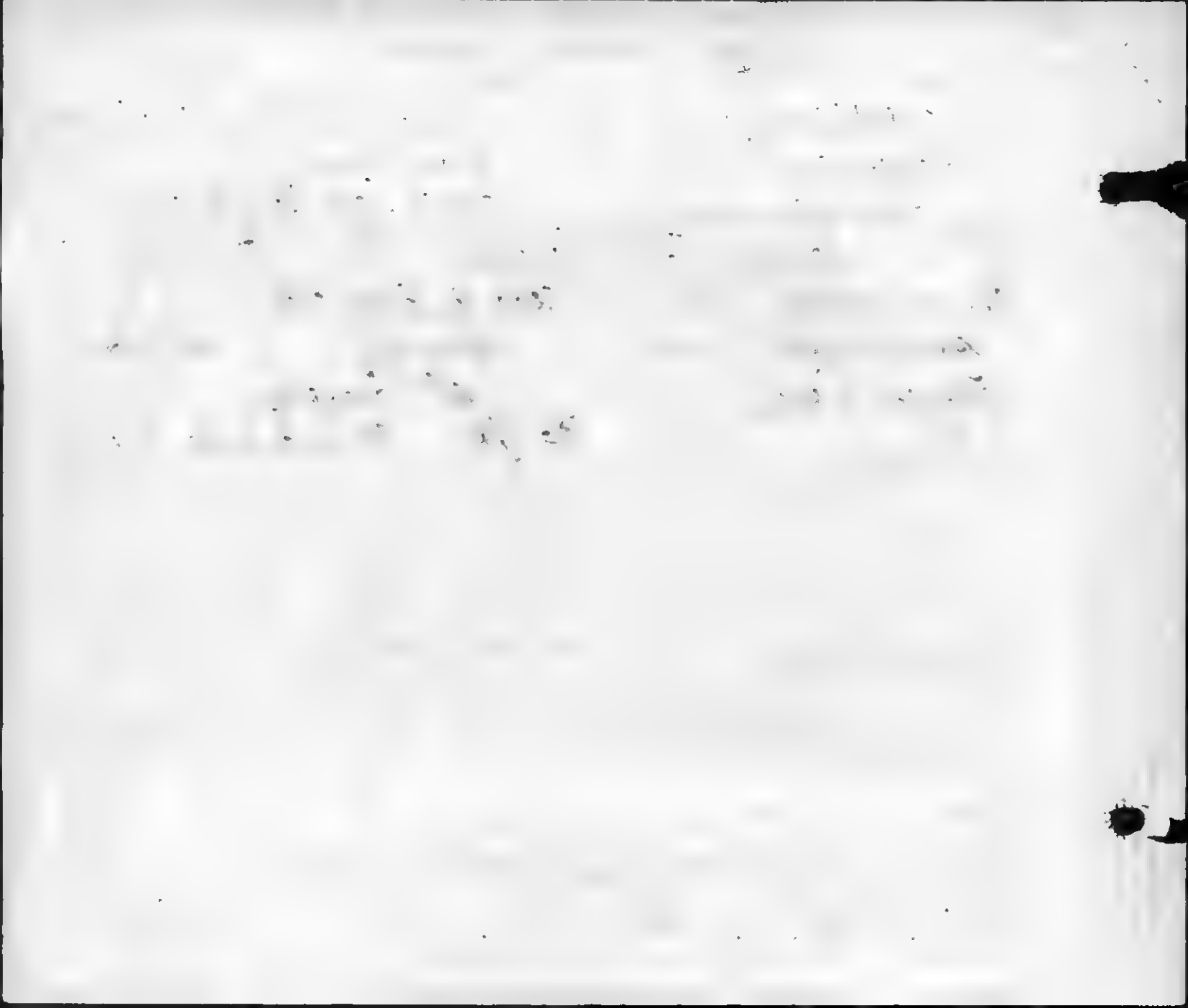
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>1 month</u>		d. STREET ADDRESS <u>2917 Stanton Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ima</u> Middle <u>B.</u> Last <u>Cross</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Coy</u>		14. MOTHER'S MAIDEN NAME <u>MAY G. M^c Greger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Daughter Mary Gertrude Cross</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Sarcoma, widespread</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>9-MOS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> 1958, to <u>March 20</u> 1959, that I last saw the deceased alive on <u>March 20</u> 1959, and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>George Sharpe</u>		ADDRESS (Street, city or town, state) <u>10511 Summit Ave Kensington, Md.</u>	
M.D. <u>3/21/59</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>George Sharpe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TPANS. & BURIAL</u>	22b. DATE THEREOF <u>3/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HANOVER CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CENTER HANOVER, MASS.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3279

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <u>West Va.</u> b COUNTY <u>MORGAN</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zinger</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Laughterty</u>		4 DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18 - 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>14</u> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STAR Paper</u>	
11. BIRTHPLACE (State or foreign country) <u>Royalton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Laughterty</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>332X</u>	
17. INFORMANT <u>Hospital Records Wife</u>		Address <u>Wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident (thrombosis)</u> DUE TO (b) <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>7 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rectal carcinoma</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 8 - 1959</u> to <u>March 14 - 1959</u> , that I last saw the deceased alive on <u>3-14</u> , 1959, and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John R. Spencer</u> M.D.		ADDRESS (Street, city or town, state) <u>Columbia Rd. Burtonsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>		DATE SIGNED <u>March 17 '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/18/1959 Fort Lincoln</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Rd. Burtonsville, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee, Inc. Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>March 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thrall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

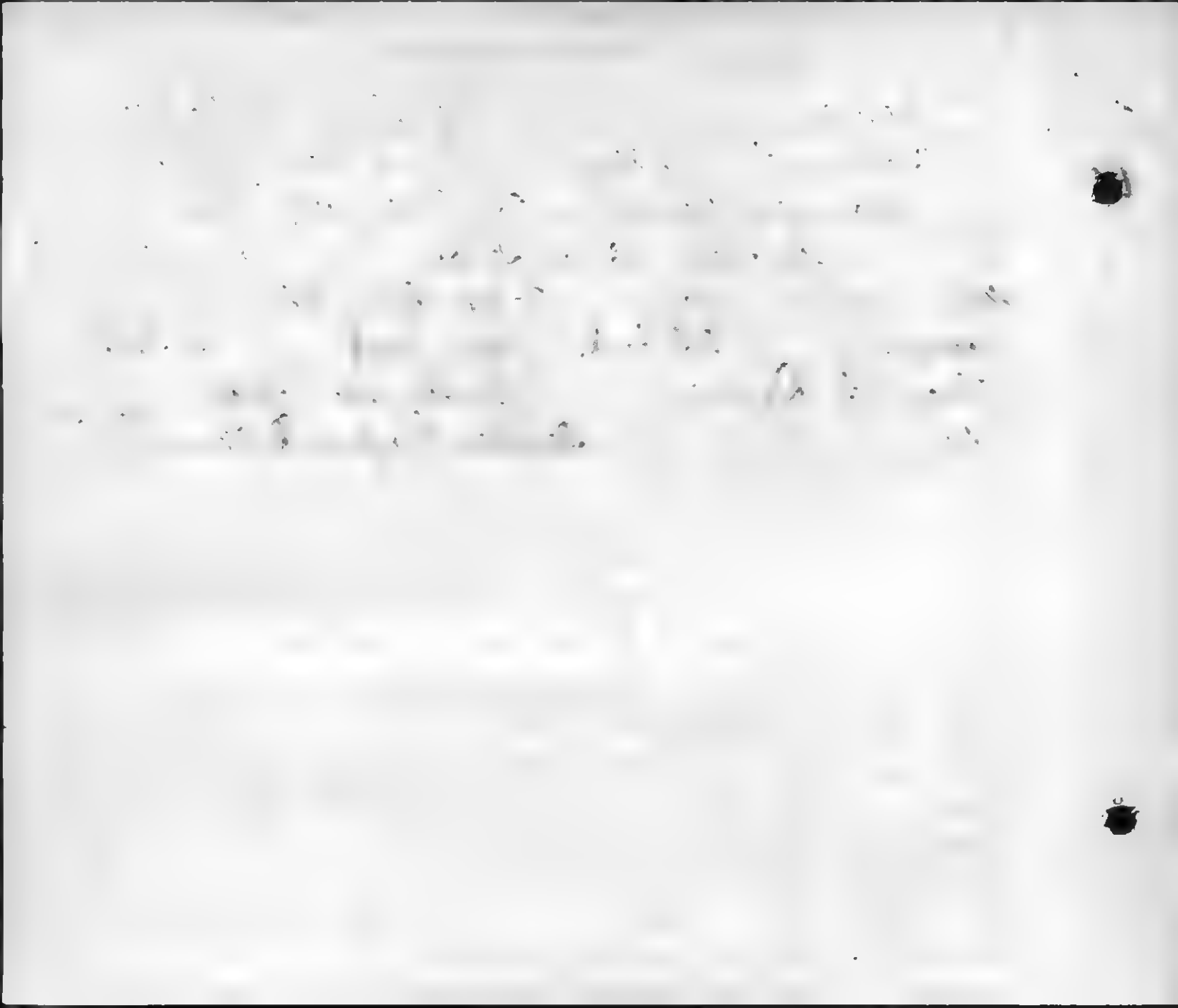
3280

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		e. STREET ADDRESS <u>5529 Warwick Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Alward</u> Middle <u>Calvin</u> Last <u>DeVoe</u>		4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>23</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elias H. DeVoe</u>		14. MOTHER'S MAIDEN NAME <u>Antoinette Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter Winifred D. Hammer</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exacerbated Retroperitoneal Prostatectomy</u> DUE TO (c) <u>30 min</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polyarteritis nodosa</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12 March, 1959</u> to <u>17 March, 1959</u> , that I last saw the deceased alive on <u>17 March, 1959</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward E. Ferguson</u> M.D.		ADDRESS (Street, city or town, state) <u>1835 E. 17th, Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD E. FERGUSON</u>		DATE SIGNED <u>17 MAR 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

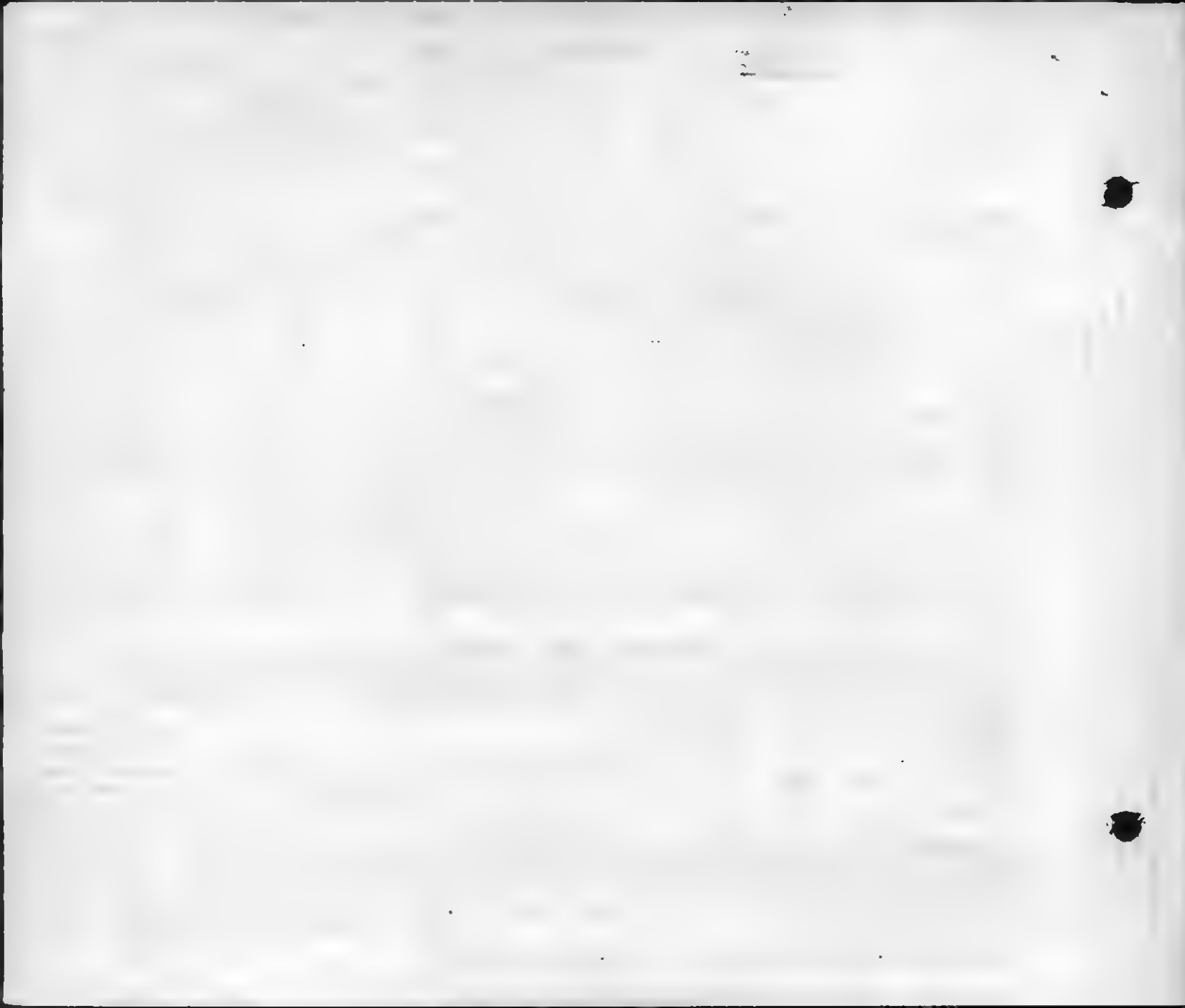
Reg. Dist. No.

03247

3281

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN b. <u>10 1/2 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9201 OLD GEORGETOWN ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>DILLINGHAM, JR.</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 7, 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ECONOMIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>WILLIAM HENRY DILLINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>ANNA FLORENCE DODSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. W. H. DILLINGHAM 9201 OLD GEORGETOWN RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u>							
420.1 DUE TO (b) <u>MYOCARDIAL INFARCTION</u> <u>2 1/2 HOURS</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CORONARY ARTERIOSCLEROSIS</u> <u>UNDETERMINED</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>54</u> , to <u>MARCH 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MARCH 19</u> , 19 <u>59</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph P. Connor</u> M.D.				ADDRESS (Street, city or town, state) <u>9420 Old Georgetown Road</u> DATE SIGNED <u>19 March 59</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>				<u>BETHESDA 14 MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 23 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farnes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3253

CERTIFICATE OF DEATH

Reg. Dist. No.

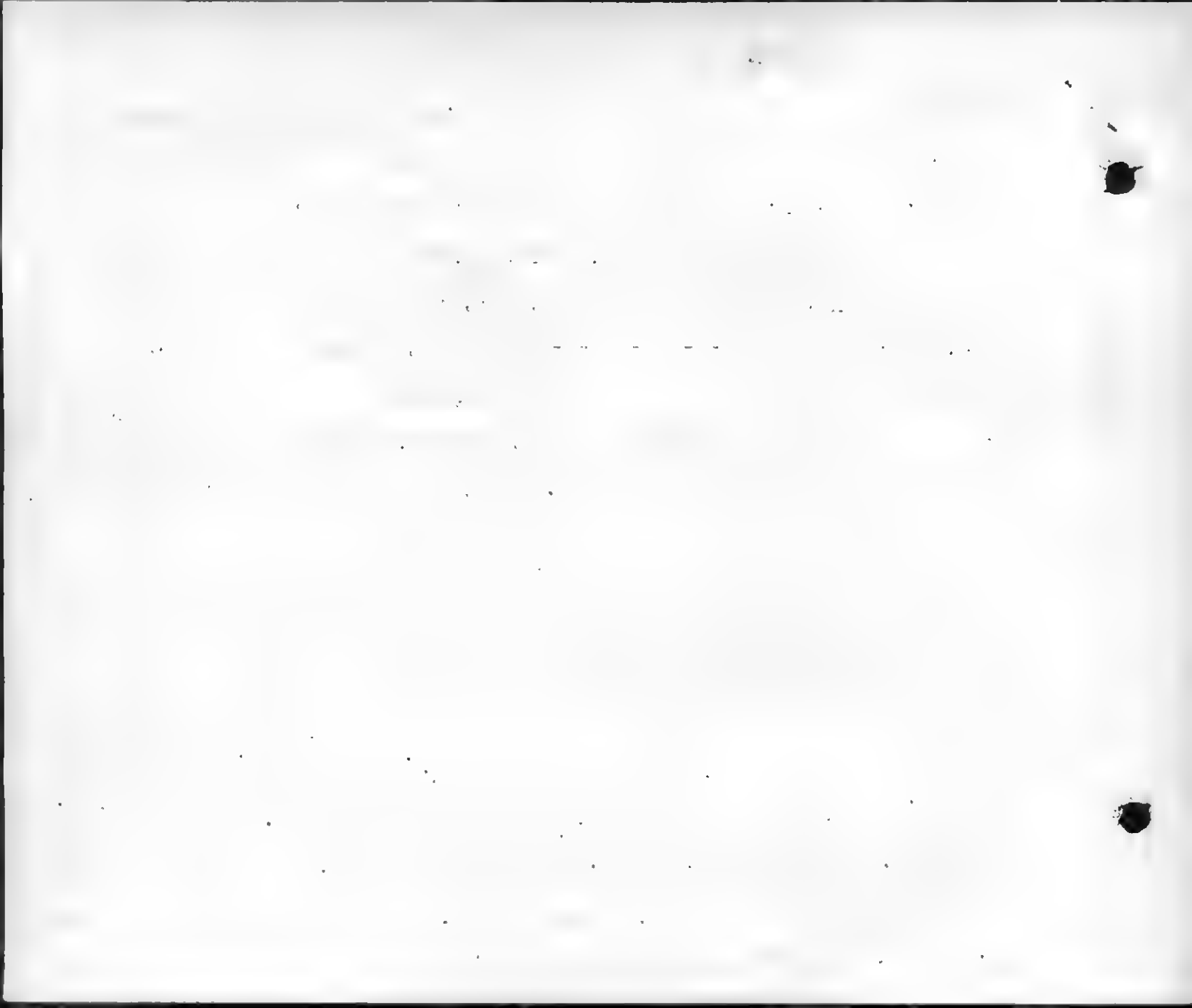
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 107 Beall Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Emily Middle F. Last DITCHBURN		4. DATE OF DEATH Month March Day 6 Year 19 59	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 4, 1883
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 8 Days 2 Hours 2 Min.	11. IF UNDER 24 HRS Hours 2 Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Toronto, Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ezekiel Firman		14. MOTHER'S MAIDEN NAME Emily Neale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Daughter		Address Mrs. Eileen H. Troop-Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 6 1/2 years 1+ years unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 15, 1958 to March 6, 1959 , that I last saw the deceased alive on March 5, 1959 , and that death occurred at 12 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) no. 809 Weirs Mill Rd. ACTUAL SIGNATURE G. Bowditch Hunter, Jr. DATE SIGNED 3/6/59 PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr. Rockville, Md.			
22a BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 3/9/59	22c. NAME OF CEMETERY OR CREMATORY St. George's Cem.	22d LOCATION (City, town, or county) (State) Trenton, Ontario, Canada
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	24a REC'D BY REGISTRAR MAR 9 '59 24b REGISTRAR'S SIGNATURE Arthur L. Hunt

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



3282

CERTIFICATE OF DEATH

Reg. Dist. No.

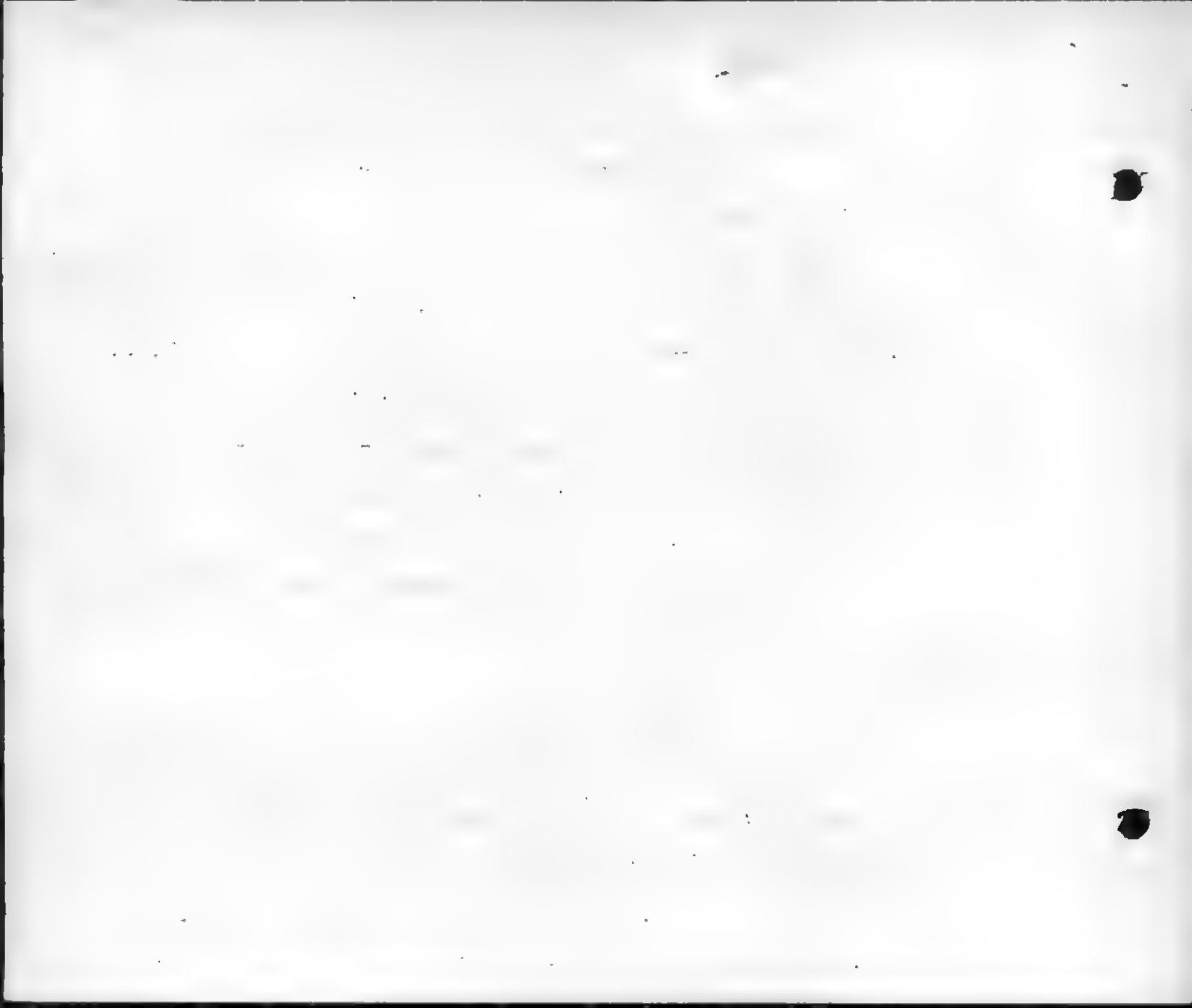
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 3 years		d. STREET ADDRESS 5815 Ipswitch Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5815 Ipswitch Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle C Last DOHERTY		4. DATE OF DEATH Month March Day 28 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 9 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John ?		14. MOTHER'S MAIDEN NAME Mary Oldfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Helen Doherty-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause (d) (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MYOCARDIAL INFARCTION 1953		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 19 56 to MARCH 28 , 1959, that I last saw the deceased alive on MARCH 29 , 19 59 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Witowski Jr. M.D.		ADDRESS (Street, city or town, state) Suite 400, 8218 Wisconsin Ave DATE SIGNED 4/28/59	
PHYSICIAN'S NAME (Type) EDWARD S. WITOWSKI JR. M.D. BETHESDA 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/59	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Catholic	22d. LOCATION (City, town, or county) (State) Alexandria, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE MAR 31 '59	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



41
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03250

3283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bluesy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>10 mo.</u>		d. STREET ADDRESS <u>1412 Ridge Pl., S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooke Grove Chronic Hosp.</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fred F. Donovan</u>		4. DATE OF DEATH <u>Mar 27 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1890</u>
9. AGE (in years) <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank F. Donovan</u>		14. MOTHER'S MAIDEN NAME <u>(Alice) Cullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Jahar F. Donovan - son</u>		Address <u>1229 V. St S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>years</u> cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3-31-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - D.C.</u>		24a. REGISTERED SIGNATURE <u>Charles S. Thomas</u>	
24b. REGISTERED SIGNATURE		DATE <u>MAR 30 '59</u>	

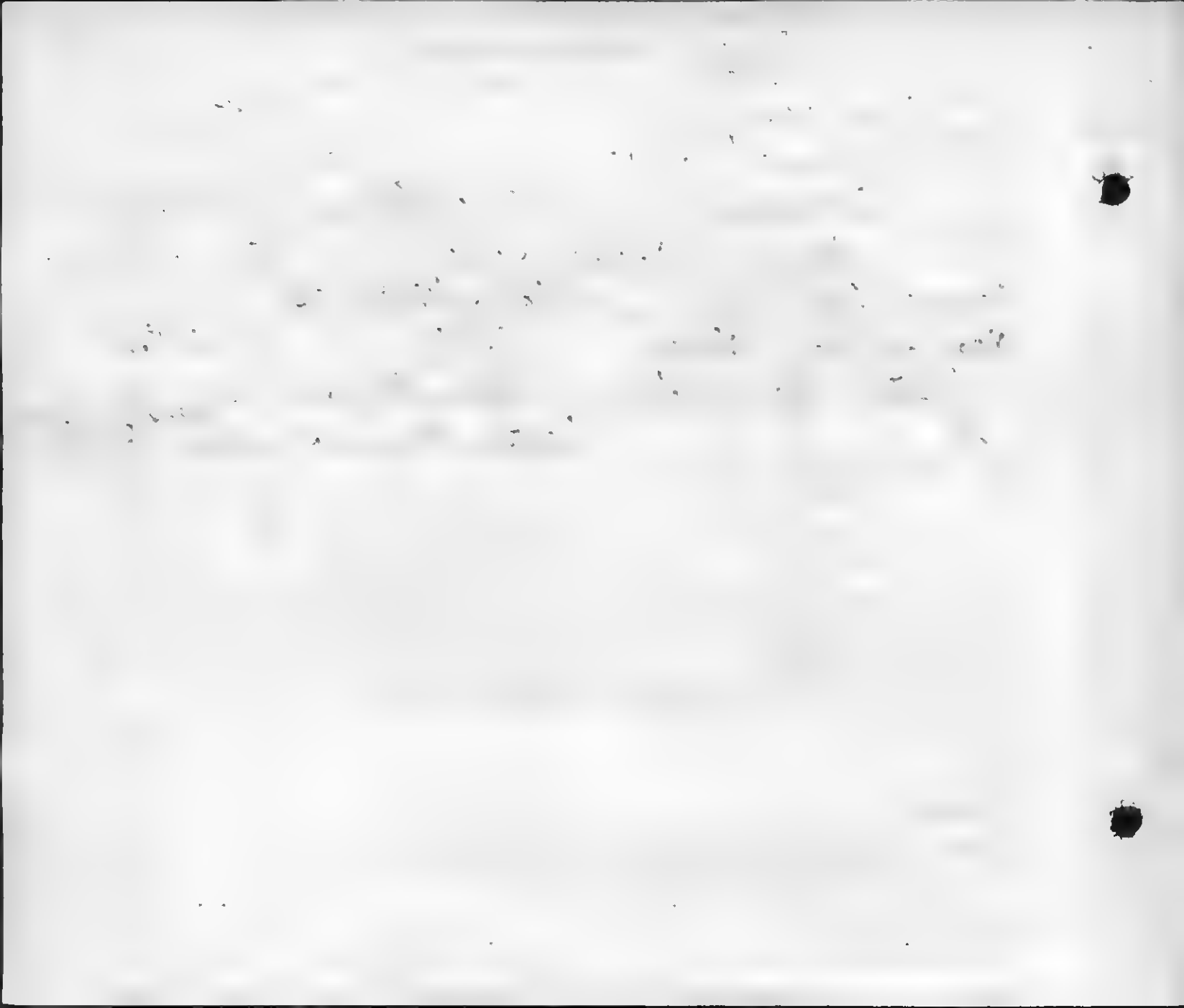
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

Item 12 Film 242 5-1-59 and														
3284														
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
CERTIFICATE OF DEATH														
Reg. Dist. No. 03251														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>7</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>5 days.</u>									
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>					d. STREET ADDRESS <u>5509 Nebraska Ave. N.W.</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>					e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Regina</u> Last <u>Dorley</u>					4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13 1922</u>		9. AGE (In years last birthday) <u>32</u> yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>X-Ray Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X-Ray</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min						
13. FATHER'S NAME <u>Walter Francis Dorley</u>					14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hamigam</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>					16. SOCIAL SECURITY NO. <u>YES</u>					17. INFORMANT Address <u>Walter Francis Dorley Jr. 1908 Evans Pkwy - Bethesda</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Clinical Shock, post operative 48 hrs,</u>										57 hrs.				
DUE TO (b) <u>Circulatory Collapse; Etiology, Adrenal</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>insufficiency, due to bilateral adrenal</u>														
DUE TO (c) <u>in action; status post laparotomy</u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>lower nephron nephrosis; adynamic ileus; fibrinous peritonitis</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
					20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>3-16 - 1959</u> to <u>3-21 - 1959</u> , that I last saw the deceased alive on <u>3-21 - 1959</u> and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) DATE SIGNED				
ACTUAL SIGNATURE <u>LINWOOD H. JOHNSON JR.</u> M.D. <u>104 Chevy Chase Dr. Chevy Chase, Md.</u>														
PHYSICIAN'S NAME (Type) <u>LINWOOD H. JOHNSON JR. M.D.</u> <u>104 Chevy Chase Dr. Chevy Chase, Md.</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>3/25/59</u>					22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>				
										22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>					24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>					24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>				



3285

CERTIFICATE OF DEATH

03252

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Bergen			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Frederick Last Dorn				4. DATE OF DEATH Month March Day 2 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 September 1918	
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR: Months 40 Days 0 Hours 0 Min 0		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Driving School		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME John Dorn				14. MOTHER'S MAIDEN NAME Amy Schiebe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO 140-09-5343		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO HEART Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATIC HEART DISEASE (c) MITRAL STENOSIS INTERVAL BETWEEN ONSET AND DEATH 1 WEEK YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 25, 1959 to March 2, 1959 , that I last saw the deceased alive on March 2, 1959 , and that death occurred at 5:25 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-3-59 NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE John A. Oates, Jr. M.D.				PHYSICIAN'S NAME (Type) John A. Oates, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-59		22c. NAME OF CEMETERY OR CREMATORY George Washington Mem. Pk.,		22d. LOCATION (City, town, or county) (State) Bergen County, N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3286

CERTIFICATE OF DEATH

03253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EDWARD DOSS		4. DATE OF DEATH Month Day Year MARCH 13 19 59					
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/88	9. AGE (In years last birthday) yrs 70	IF UNDER 1 YEAR Months Days Hours Min 13 19 59		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) VIRGINIA			
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME NED DOSS		14. MOTHER'S MAIDEN NAME DAPHNE N. HANCOCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT HOSPITAL RECORD Address OLNEY			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 HR. YEARS		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 1 1957 , to MARCH 12 1959 , that I last saw the deceased alive on MARCH 12 1959 , and that death occurred at 3:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. W. BIRD, M.D.		M.D. Olney, Md.					
PHYSICIAN'S NAME (Type) J. W. BIRD, M.D.		OLNEY, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-17-59	22c. NAME OF CEMETERY OR CREMATORY LOCUST CHAPEL		22d. LOCATION (City, town, or county) (State) HT HOLTON MD.			
23. FUNERAL DIRECTOR'S SIGNATURE FRANCIS BOTTHOM, ENHOTT CITY MD.		ADDRESS ENHOTT CITY MD.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

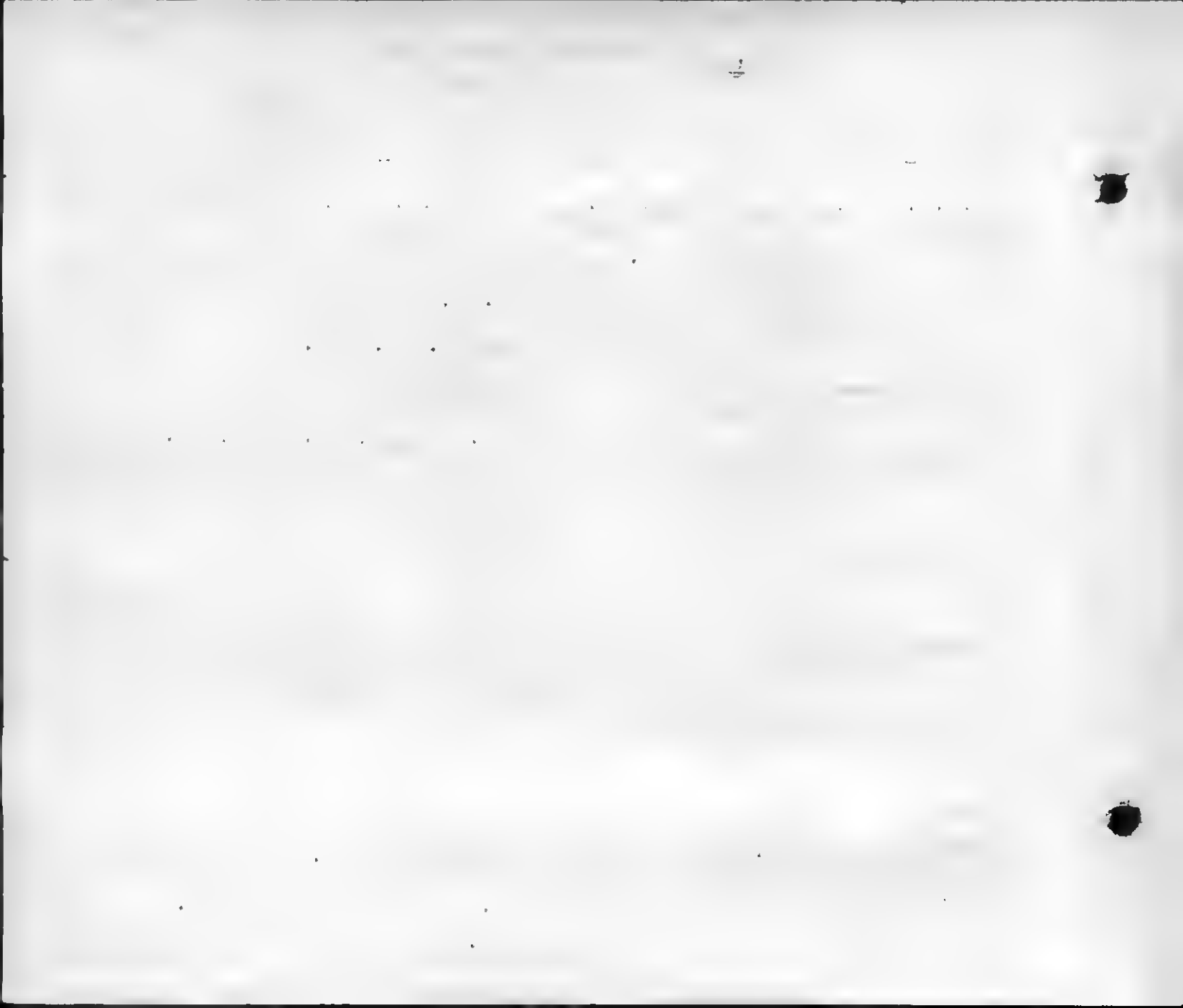
Reg. Dist. No.

3287

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Damascus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Damascus	
c. LENGTH OF STAY IN 1b years		d. STREET ADDRESS R.F.D. # 1, Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 1, Gaithersburg, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle L. Last Duvall		4. DATE OF DEATH Month March Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Montg. Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Brewer King	
14. MOTHER'S MAIDEN NAME Luvenia Burns		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT John B. Duvall, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma of uterus with generalized metastases 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 15, 1958 to March 24, 1959 , that I last saw the deceased alive on March 23, 1959 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 3/25/59 ACTUAL SIGNATURE James P. Kerr PHYSICIAN'S NAME (Type) James P. Kerr Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/26/59	22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	22d. LOCATION (City, town or county) (State) Damascus, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Woloszewski		24a. REC'D BY REGISTRAR DATE MAR 26 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

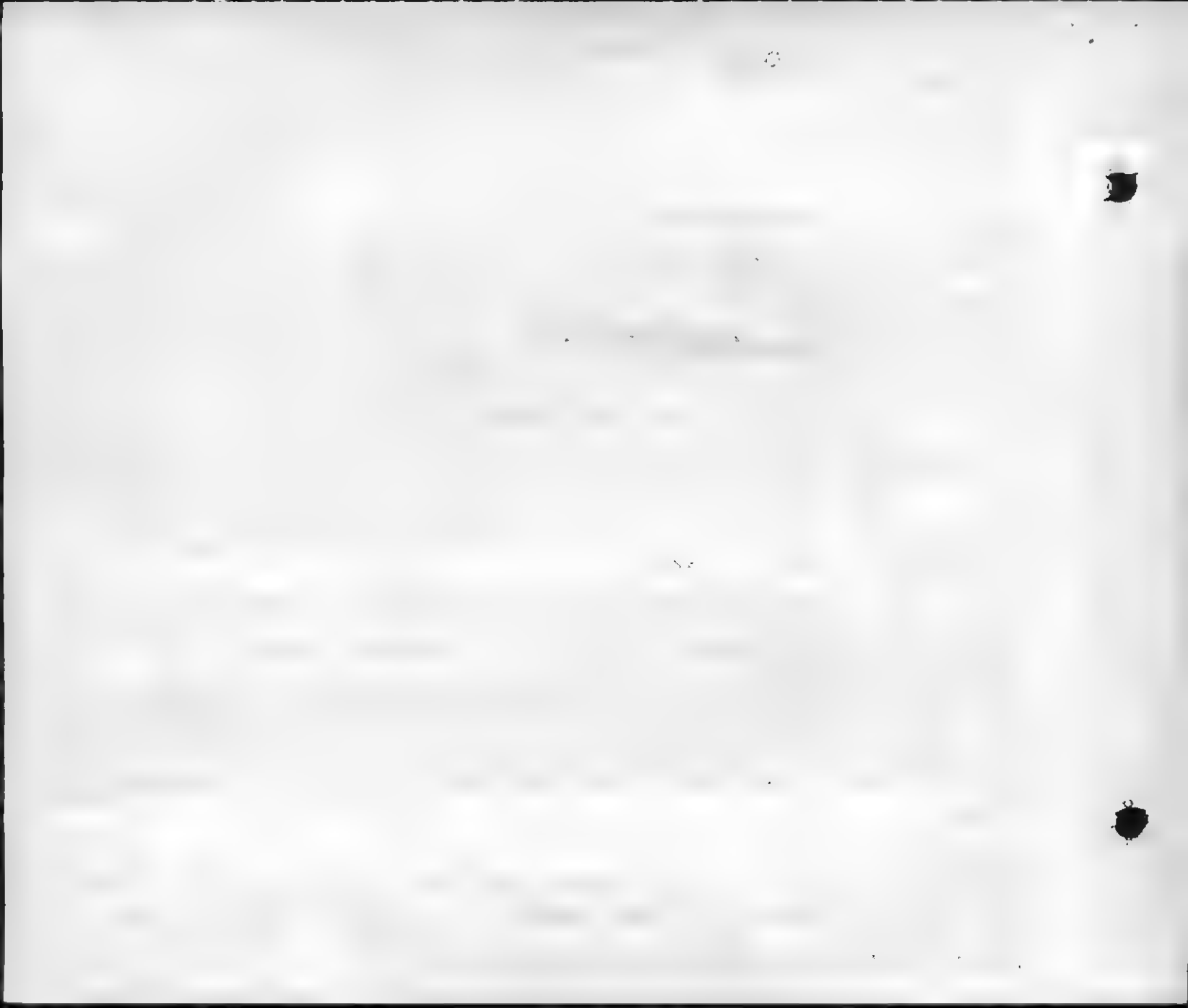
03255

3288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u> Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STILLER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALLDORF</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREENBANK HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>HARRISON</u> Middle <u>EDWARDS</u> Last		4. DATE OF DEATH Month <u>APR.</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 10, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATE PLANT. Roads</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND STATE ROAD COMM.</u>	9. AGE (In years last birthday) <u>77</u> yrs
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT E. EDWARDS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ST. HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>4433</u>	17. INFORMANT <u>1708 Holiday Terrace, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>4433</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar. 14, 1959</u> , to <u>MAR. 17, 1959</u> , that I last saw the deceased alive on <u>Mar. 14, 1959</u> , and that death occurred at <u>9:00 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James L. Laubach</u> M.D.		DATE SIGNED <u>1806 10th St.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>		<u>HYATTSMILL, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3289

CERTIFICATE OF DEATH

03256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY in 1b 19 1/2 months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium						e. STREET ADDRESS 3000 Macomas Ave.				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Palmer		First A.		Middle Eliot		Last		4. DATE OF DEATH Month March		Day 1	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1875 July 3, 1877		9. AGE (In years last birthday) 82 3/4 yrs		10. IF UNDER 1 YEAR Months 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY War Dept.		11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Randolph Eliot						14. MOTHER'S MAIDEN NAME Mary Palmer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Span-Amer.?		17. INFORMANT Address Kensington Gardens Sanitarium, Kensington, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO or Extensive Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis and (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH Months 5 yrs.											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) No injury							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July , 1957, to July 1 , 1959, that I last saw the deceased alive on Feb 22 , 1959, and that death occurred at 9:05 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE James J. Foster				ADDRESS (Street, city or town, state) 1746 K St N.W.				DATE SIGNED 3/1/59			
PHYSICIAN'S NAME (Type) JAMES J. FOSTER											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l				22d. LOCATION (City, town, or county) (State) Ft. Myer Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons				ADDRESS 1736 Pa Ave. NW				24a. REC'D BY REGISTRAR MAR 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03257

Reg. Dist. No.

3290

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b Silver Spring	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,130 Greenock Road		e STREET ADDRESS / 10,103 Greenock Road	
3 NAME OF DECEASED (Type or print) First ELIZABETH Middle L. Last EVANS		4 DATE OF DEATH Month MARCH Day 10 Year 19 59	
5. SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/81
9 AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 74 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12 CITIZEN OF WHAT COUNTRY U.S.A.		13 FATHER'S NAME THOMAS F. LINTHICUM	
14 MOTHER'S MAIDEN NAME MARGARET BEALL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16 SOCIAL SECURITY NO. NONE		17 INFORMANT Mr. George L. Evans, 10,130 Greenock Rd. Silver Spring, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myelogenous leukemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 15 mon.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1957, March 10, 1959 , that I last saw the deceased alive on March 9, 1959 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. B. Washington M.D.		ADDRESS (Street, city or town, state) 6234 Sa Ave NW Wash. D.C. DATE SIGNED 3/10/59	
PHYSICIAN'S NAME (Type) Daniel B. Washington MD.		6234 C-a AVE NW. Wash. D.C.	
22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/12/59	22c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23 FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR MAR 11 '59		24b REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3291

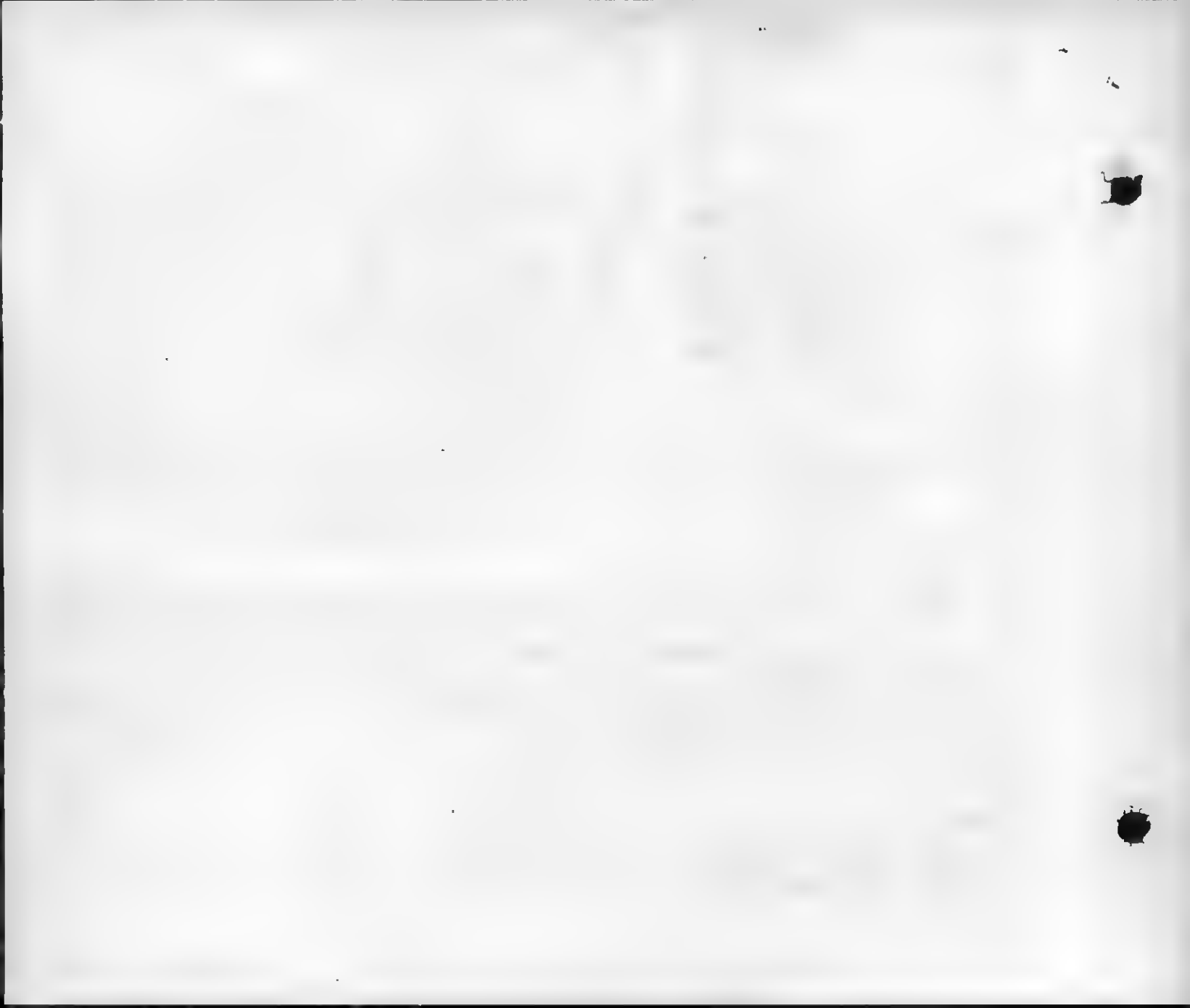
CERTIFICATE OF DEATH

03258

3000 M^cComas Ave.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u> c. LENGTH OF STAY IN b. <u>3 yrs 1 mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland - Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington, Bethesda Sanitarium</u>		d. STREET ADDRESS <u>5910 Lone Oak Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John T. Ferguson</u> First Middle Last		4. DATE OF DEATH <u>3</u> / <u>15</u> / <u>1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1882</u> 9. AGE (In years last birthday) <u>76</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Thompson</u>	
14. MOTHER'S MAIDEN NAME <u>Jane Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Forrest E. Ferguson - Item #2 - Son</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>Hypertensive Vascular Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cerebral arteriosclerosis.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3/11/59 - 3/15/59</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>March 15, 1959</u>	
21. I certify that I attended the deceased from <u>March 7, 1959</u> to <u>March 15, 1959</u> , that I last saw the deceased alive on <u>March 15, 1959</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo. A. Gray, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Chevy Chase Dr. 3/15/59</u>	
PHYSICIAN'S NAME (Type) <u>Geo. A. GRAY, JR., M.D.</u>		<u>Chevy Chase 15, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Remington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Remington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>		24. REC'D BY REGISTRAR <u>MAR 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			



3292

CERTIFICATE OF DEATH

03259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENNMONT</u>				c. LENGTH OF STAY IN 1b <u>16 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2804 SHERATON ST</u>				d. STREET ADDRESS <u>2804 SHERATON ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW ROSS FOLWIN</u>				4. DATE OF DEATH Month Day Year <u>3 - 19 - 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1-31-1897</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>			
11. BIRTHPLACE (State or foreign country) <u>FAIRFAX CO VA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ANDREW R FOLWIN</u>				14. MOTHER'S MAIDEN NAME <u>DELLA LANHAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MARY E SLARK</u> Address <u>GLENNMONT, MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>400</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary heart disease</u> DUE TO <u>Hypertensive heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>INTERVAL BETWEEN ONSET AND DEATH 20 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 10, 1957</u> to <u>March 19, 1959</u> that I last saw the deceased alive on <u>March 19, 1959</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Patricia C. Chambers</u> M.D.				ADDRESS (Street, city or town, state) <u>12020 Georgia Wheaton, Md</u>			
DATE SIGNED <u>March 19, 1959</u>							
PHYSICIAN'S NAME (Type) <u>Patricia C. Chambers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Fa. 1st 11</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>3072 M St</u>				24a. REC'D BY REGISTRAR <u>MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Fox		4. DATE OF DEATH March 4 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/82
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Isabel L. Fox-wife-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Emphysema & C.H.F. DUE TO (c) Generalized Arteriosclerosis & gastric ulcer		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/58 to 3/4/59 , that I last saw the deceased alive on 3/4/59 , and that death occurred at 6:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones		ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 3/4/59	
PHYSICIAN'S NAME (Type) STEPHEN N. JONES		ROCKVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	22b. DATE THEREOF 3-7-59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum	22d. LOCATION (City, town, or county) (State) Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers, Pages 1 and 2, and they should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3294

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Alabama b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Rt. #2, Box 88	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Brenda Middle Kay Last FRAZIER		4. DATE OF DEATH Month March Day 1 Year 1959	
5 SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-57
9 AGE (In years last birthday) 1 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Alabama		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. FRAZIER		14 MOTHER'S MAIDEN NAME Bobbie Jean WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (M) Mrs. Bobbie Jean Frazier, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 758.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post operative scaphocephaly (c) Hydrocephalus		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 16 mos. 16 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 16, 1959 , to March 1, 1959 , that I last saw the deceased alive on February 28, 1959 , and that death occurred at 7:05A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Druckemiller M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3-2-59	
PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MB, USN Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-59	
22c. NAME OF CEMETERY OR CREMATORY Green Acres		22d. LOCATION (City, town, or county) (State) Brewton, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frazier	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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3295

CERTIFICATE OF DEATH

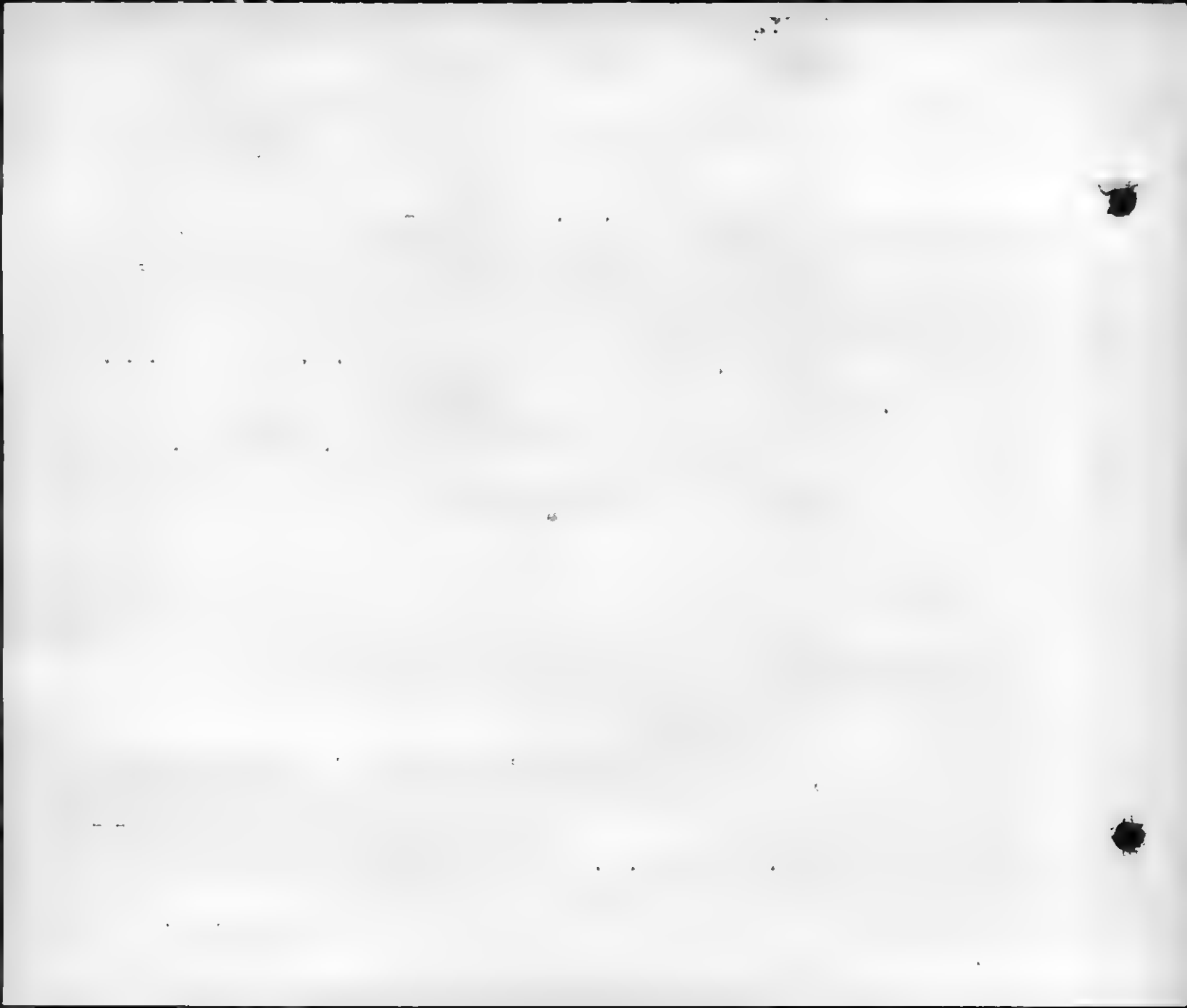
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 99 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 9206 - 50th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Janet Middle Louise Last Fritter			4. DATE OF DEATH Month March Day 4 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1955		9. AGE (In years last birthday) 4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Edward S. Fritter			14. MOTHER'S MAIDEN NAME Edna Drury		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute lymphocytic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 16 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from November 25, 19 58 to March 4, 19 59 , that I last saw the deceased alive on March 4, 19 59 , and that death occurred at 11:55 A M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Peter S. Mueller, M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 3-4-59	
PHYSICIAN'S NAME (Type) Peter S. Mueller, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 6, 1959	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons			ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE MAR 9 '59
					24b. REGISTRAR'S SIGNATURE Arthur L. Hines

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3296

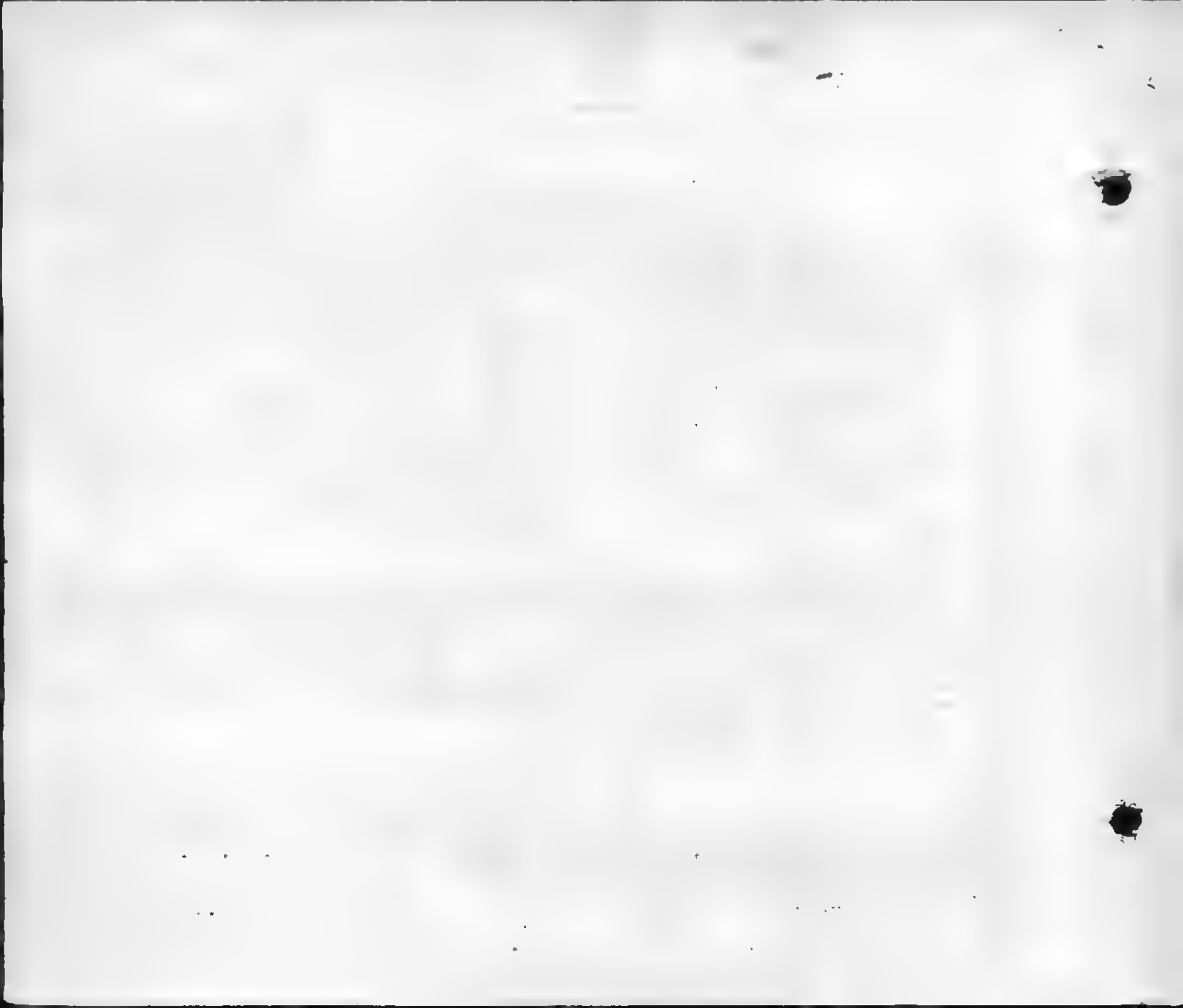
CERTIFICATE OF DEATH

03263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William E. FUREY</u>				4. DATE OF DEATH Month Day Year <u>3 23 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/04</u>		9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward William Furey</u>				14. MOTHER'S MAIDEN NAME <u>Alice Walsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes.</u>		17. INFORMANT Address <u>Edward William Furey (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive protein hemolysis</u> <u>1551</u> DUE TO <u>chronic 3 minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Calcium 2 high salts</u> (c) <u>mod.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> 19 <u>58</u> to <u>3-23</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3-22</u> 19 <u>59</u> , and that death occurred at <u>5:15</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul Kinman</u> M.D. <u>Washington Clinic - D.C.</u>							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Paul Kinman, Washington Clinic, Washington, D. C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-25-59</u>		<u>Gate of Heaven</u>		<u>Montgomery Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda 14, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Krawa</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3297
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03264

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> - b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>3000 McConnaughy Ave.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Garden Sanitorium</i>		d. STREET ADDRESS <i>12719 Blaine Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Agnes</i> First <i>N</i> Middle <i>Gannon</i> Last		4. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1873</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>10</i> Days <i>16</i> Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ireland</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Michael Neelon</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hughes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Marian A. Gannon - Item #2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fractured Left Femur - September 2, 1959</i> DUE TO (c) <i>Fractured Left Femur - September 2, 1959</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured Left Femur - September 2, 1959</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 9, 1956</i> to <i>March 9, 1959</i> , that I last saw the deceased alive on <i>March 9, 1959</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>James M. Loftus</i> M.D. <i>1673 Park Road N.W., Wash., D.C. 1959</i> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <i>James M. Loftus</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/13/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda 14, Md.</i>		24. REC'D BY REGISTRAR <i>MAR 11 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			



Item 8, Film G241, 4, 1959

Item 8, Film G241, 4, 1959

3298

CERTIFICATE OF DEATH

03265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>748 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherry Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Resmor Sanitarium Bethesda, Md.</i>						e. STREET ADDRESS <i>4750 Cherry Chase Drive</i>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clara Andrina Garwood</i>						4. DATE OF DEATH Month Day Year <i>March 14 1959</i>					
5. SEX <i>female</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 18, 1877</i>		9. AGE (In years last birthday) <i>81 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min <i>8 26</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Norway</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>XXXXXXXXX Unknown</i>						14. MOTHER'S MAIDEN NAME <i>XXXXXXXXX, Karen Jensen</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Mrs Elizabeth Chamberlin - 4750 Cherry Chase Dr</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis; Essential Hypertension; Coronary Artery; and Small Vessel Disease</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks.</i> <i>3 years.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>May 27, 1957</i> , to <i>March 14, 1959</i> , that I last saw the deceased alive on <i>March 8, 1959</i> , and that death occurred at <i>11:00 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Bertram F. Schaefer M.D. 1780 Massachusetts Ave. N.W. 3/14/59 Wash. D.C.</i>											
ACTUAL SIGNATURE <i>Bertram F. Schaefer</i>				PHYSICIAN'S NAME (Type) <i>Bertram F. Schaefer M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial-Transit</i>		22b. DATE THEREOF <i>3-16-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cem.</i>				22d. LOCATION (City, town, or county) <i>Evanston, Illinois</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>				ADDRESS <i>Bethesda, Md.</i>				24a. REG'D BY REGISTRAR DATE <i>18 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3299

CERTIFICATE OF DEATH

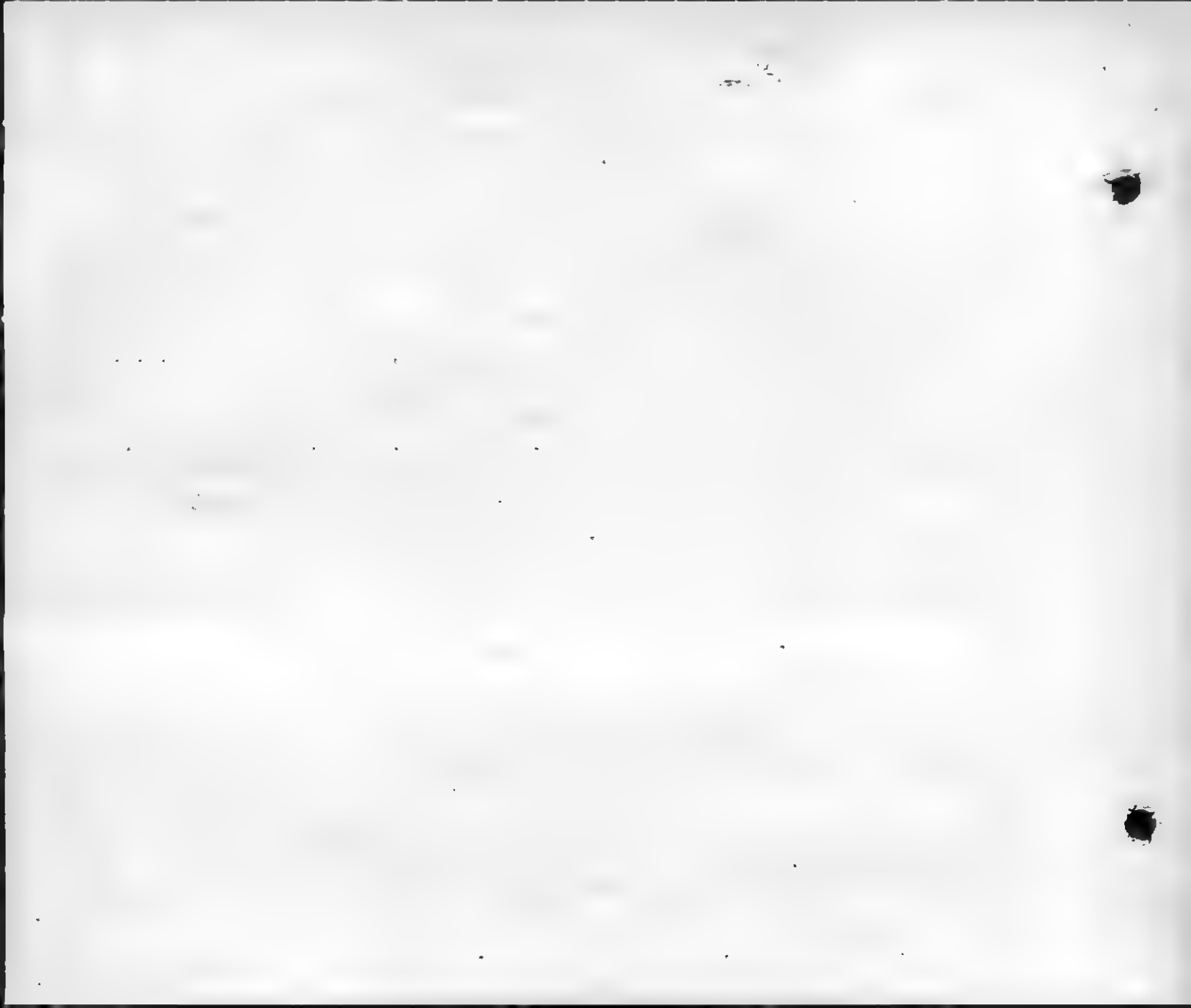
03266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN It Since Nov. 1941	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9302 Worth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IDA MAY GRAHAM		4. DATE OF DEATH Month Day Year MARCH 28 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/77
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Potomac, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN PUMPHREY CONNELL	
14. MOTHER'S MAIDEN NAME EMMA BENTON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Mrs. Marjorie G. Leedy, 9302 Worth Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Deкомпensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Silver Spring, Md.		(County) (State)	
21. I certify that I attended the deceased from 1946 to 28 March, 1959 , that I last saw the deceased alive on 27 March, 1959 , and that death occurred at 8 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud		ADDRESS (Street, city or town, state) 906 Coleridge Rd Silver Spring, Md.	
DATE SIGNED 3/24/59		22a. REC'D BY REGISTRAR DATE MAR 30 '59	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) ROCKVILLE, MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS Silver Spring, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3300

CERTIFICATE OF DEATH

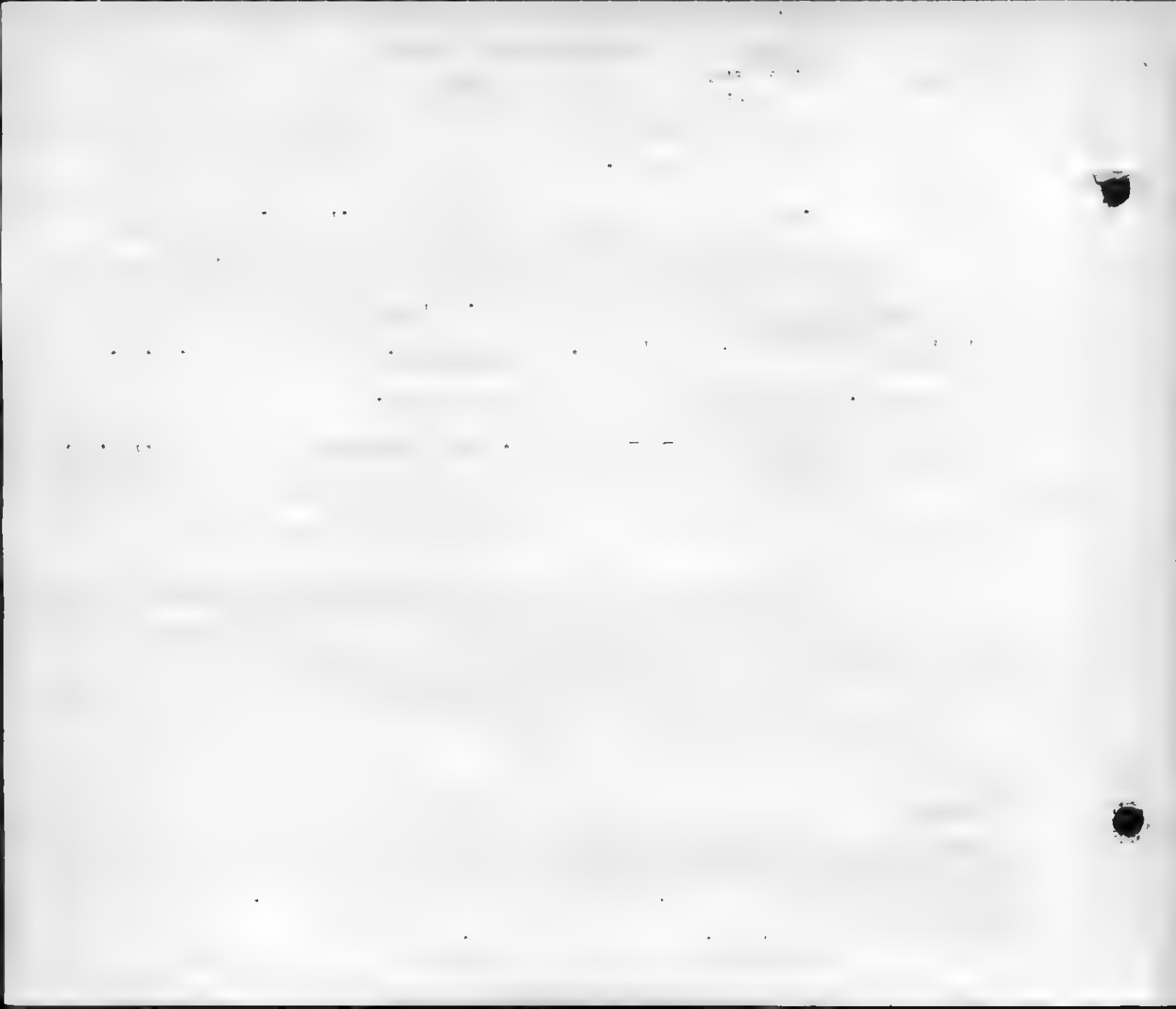
Reg. Dist. No.

03267

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 3 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 735 Sligo Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Temple Byrd Greenstreet				4. DATE OF DEATH Month March Day 12 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1868	9. AGE (in years last birthday) 90 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B'd'g Contractor (ret) B'd'g Ind.				10b. KIND OF BUSINESS OR INDUSTRY Essex Co. Virginia		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME William F. Greenstreet				14. MOTHER'S MAIDEN NAME Rebecca L.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no				16. SOCIAL SECURITY NO. 578-44-5324			
17. INFORMANT Mrs. Rocco Pezzella				Address 735 Sligo Ave., S. S.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion							3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Generalized arteriosclerosis							10 years
(c) Senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office, etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1-29, 1959 to 3-12, 1959 , that I last saw the deceased alive on 3-12, 1959 , and that death occurred at 8:50 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Shoemaker				ADDRESS (Street, city or town, state) 8005 Woodbury Drive Silver Spring, Md			
DATE SIGNED 3-16-59							
PHYSICIAN'S NAME (Type) N. C. Shoemaker, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/16/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 1 M 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3301

CERTIFICATE OF DEATH

03268

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 63 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Washington b. COUNTY Eatonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 4 x - 3 d. STREET ADDRESS - - - - - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Albert William GROTJOHAN			4. DATE OF DEATH Month Day Year March 30 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-00		9. AGE (In years last birthday) yrs. Months Days Hours Min. 58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diplomatic Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of State		11. BIRTHPLACE (State or foreign country) Holland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Albert W. GROTJOHAN				
14. MOTHER'S MAIDEN NAME Martina VOORRIPS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 15/9/19 to 8/30/50				
16. SOCIAL SECURITY NO. None			17. INFORMANT (W) Mrs. Helen Grotjohan, Washington, D. C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, pancreas, with metastasis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 mos.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital			
20f. (City or town) Bethesda		20g. (County) Montgomery		20h. (State) Maryland			
21. I certify that I attended the deceased from January 26, 1959 , to March 30, 1959 , that I last saw the deceased alive on March 30, 1959 , and that death occurred at 4:05 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 3-31-59							
ACTUAL SIGNATURE Joseph T. Horgan		M. D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) Arlington		22e. (State) Virginia		22f. REGISTRAR'S SIGNATURE Arthur S. Kraus			
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines Co.		23a. REC'D BY REGISTRAR APR 2 '59		23b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



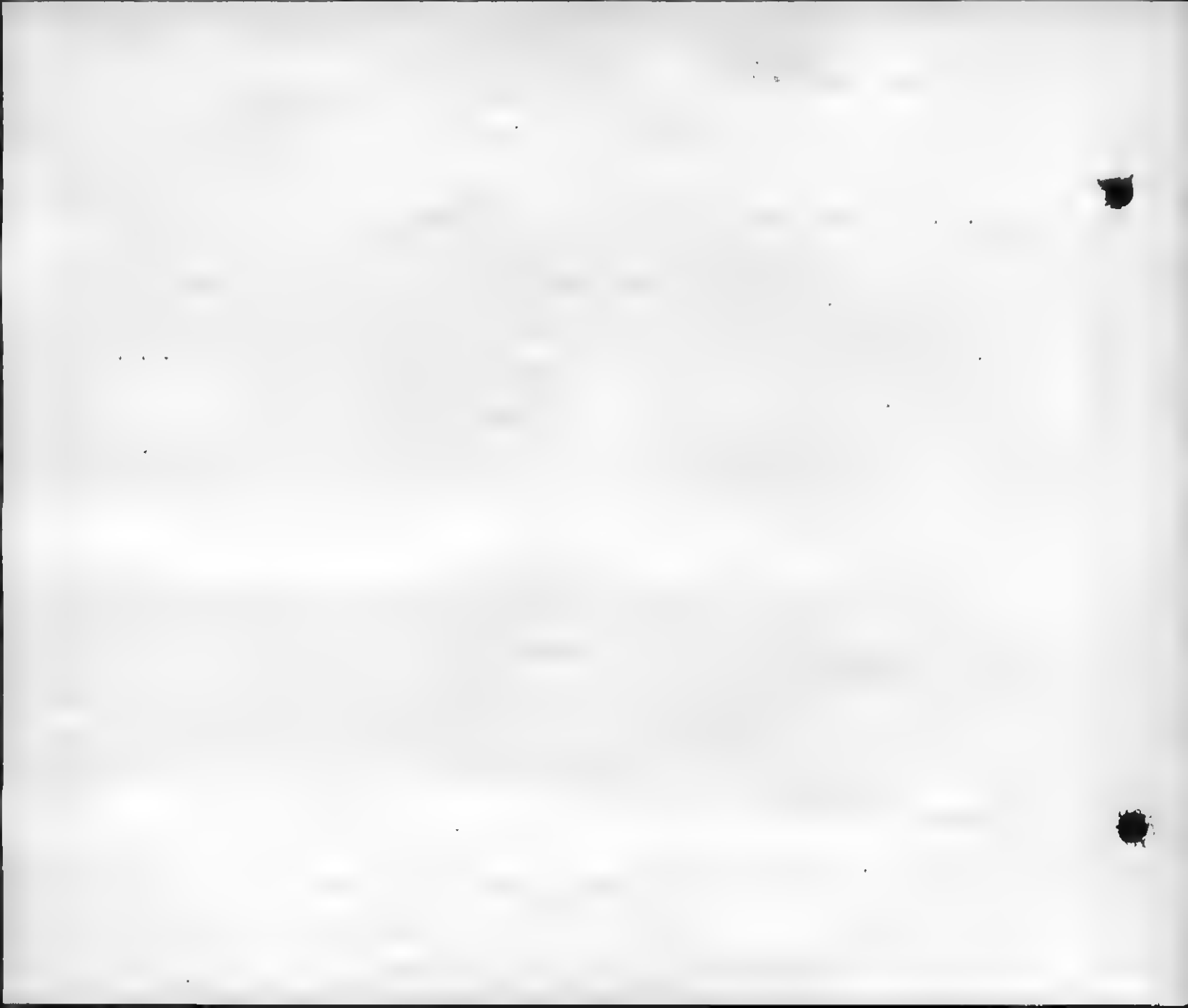
3302

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 42 days		2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 8727 Albemarle Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cheryl Jean GWINN		4. DATE OF DEATH Month Day Year March 9 1959	
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-19-53
9 AGE (In years last birthday) 5 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William E. GWINN		14 MOTHER'S MAIDEN NAME Carrie A. ZAUN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (M) Mrs. Carrie Gwinn, same as #2 above		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Block, complete DUE TO Congenital Heart Disease (c) (Ventricular septal defect)		INTERVAL BETWEEN ONSET AND DEATH Immediate 3 1/2 weeks From birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 26, 1959 , to March 9, 1959 , that I last saw the deceased alive on March 9, 1959 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Douglas R. Koth		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNM	
DATE SIGNED 3-9-59			
PRINTED NAME (Type) D. R. KOTH LT MC USN		Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 3-11-59		22b. DATE THEREOF 3-11-59	
22c. NAME OF CEMETERY OR CREMATORY Pawhuska Cemetery		22d. LOCATION (City, town, or county) (State) Pawhuska Oklahoma	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS R.A. Pumphrey Funeral Home, Bethesda, Md.	
24a. REC'D BY REGISTRAR MAR 11 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate is signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3303

CERTIFICATE OF DEATH

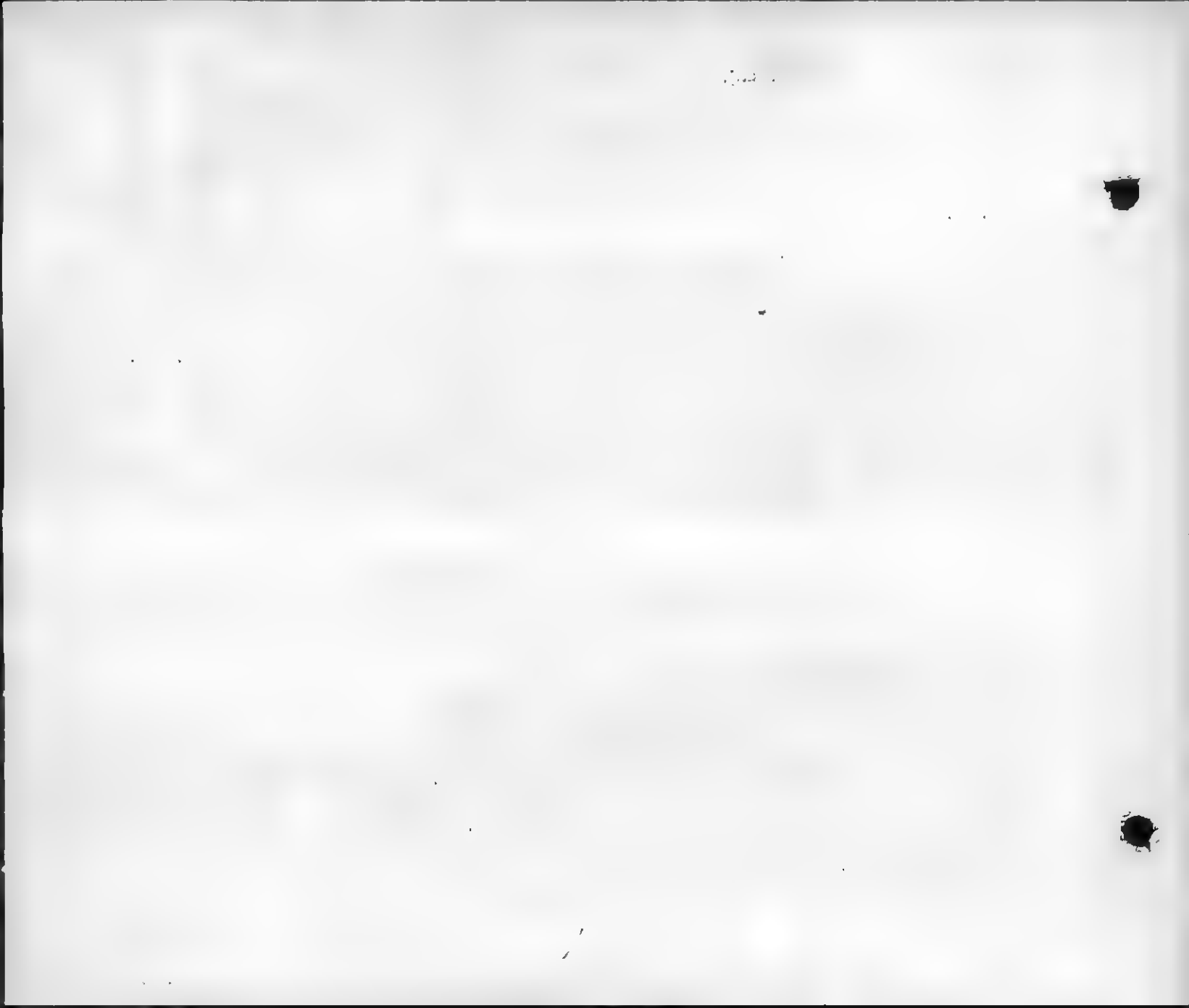
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 83 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 603 Timber Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Artemis Jacqueline HAASE			4. DATE OF DEATH Month Day Year March 31 1959		
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-10-17		9. AGE (In years last birthday) yrs. 41		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY - - - - -		13. BIRTHPLACE (State or foreign country) Iowa	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME Albert H. WESSEL		16. MOTHER'S MAIDEN NAME Katherine BEATTY	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO.		19. INFORMANT Address (H) Richard A. Haase, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic anaplastic carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from January 7, 1959 , to March 31, 1959 , that I last saw the deceased alive on March 31, 1959 , and that death occurred at 1:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 3-31-59					
ACTUAL SIGNATURE E. M. Hemness M.D. U. S. Naval Hospital, NMMC 3-31-59 PHYSICIAN'S NAME (Type) E. M. HEMNESS, LT, MC, USN Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-3-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) (State) Arlington Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Pearson Funeral Home, Falls Church, Va.		24a. REC'D BY REGISTRAR APR 2 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Brand					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3304

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 15 17 days		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 1013 New Jersey Ave., S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Morris Mason HALL		4. DATE OF DEATH Month Day Year March 30 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-04
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Mason HALL		14. MOTHER'S MAIDEN NAME Ida SHEA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO 717-07-6673	
17. INFORMANT (B) Jerry J. Hall, Washington, D. C.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, colon, with metastasis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to March 30 , 19 59 , that I last saw the deceased alive on March 30 , 19 59 , and that death occurred at 3:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NVMC 3-30-59			
ACTUAL SIGNATURE Mr. ROINER, LT, MC, USN		PHYSICIAN'S NAME (Type) Bethesda 14, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart's Funeral Home, 30 H St., NE, Wash., DC		24a. REC'D BY REGISTRAR APR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3305

CERTIFICATE OF DEATH

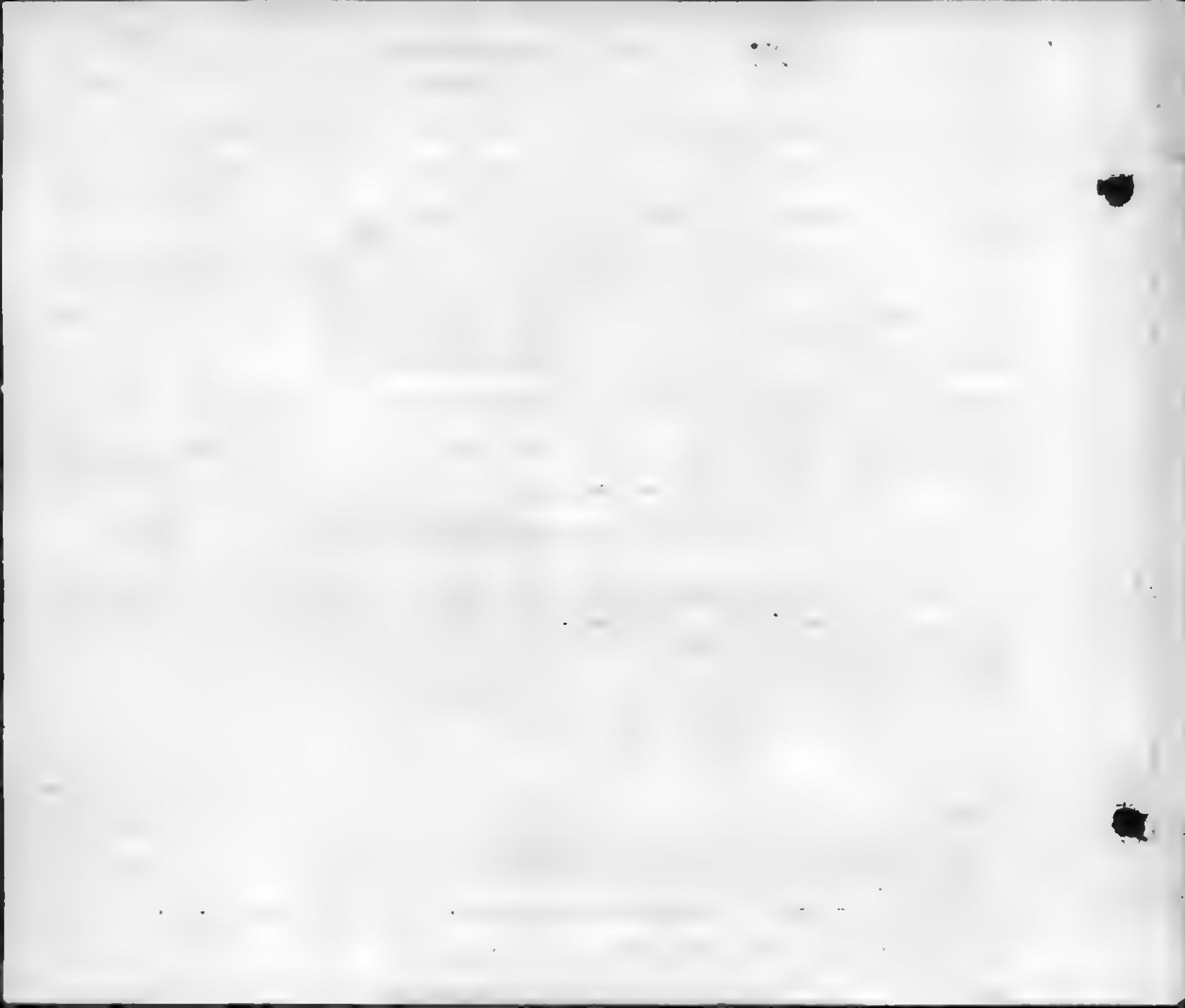
03272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN TB <u>2 weeks</u>				d. STREET ADDRESS <u>4801 Chevy Chase Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Newton</u> Middle <u>Torkington</u> Last <u>Hammer</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 6, 1883</u> 75 yrs.	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Evening Bk.</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Isaac Newton Hammer</u>				14. MOTHER'S MAIDEN NAME <u>Miriam Henry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>578-10-2423A</u>			
17. INFORMANT <u>Brother, Frederick P. Hammer D.C.</u>				Address <u>5016 Howard Ave. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Premia</u>							
4410 X DUE TO <u>Arteriosclerosis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u>							
(c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary infarction</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>Mar 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>16 March</u> , 19 <u>59</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u> M.D. <u>4413 Bradley Lane</u>				<u>3/16/59</u>			
PHYSICIAN'S NAME (Type) <u>BRADLEY D. HODGKINS Bethesda Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda 14, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>MAR 19 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3306

CERTIFICATE OF DEATH

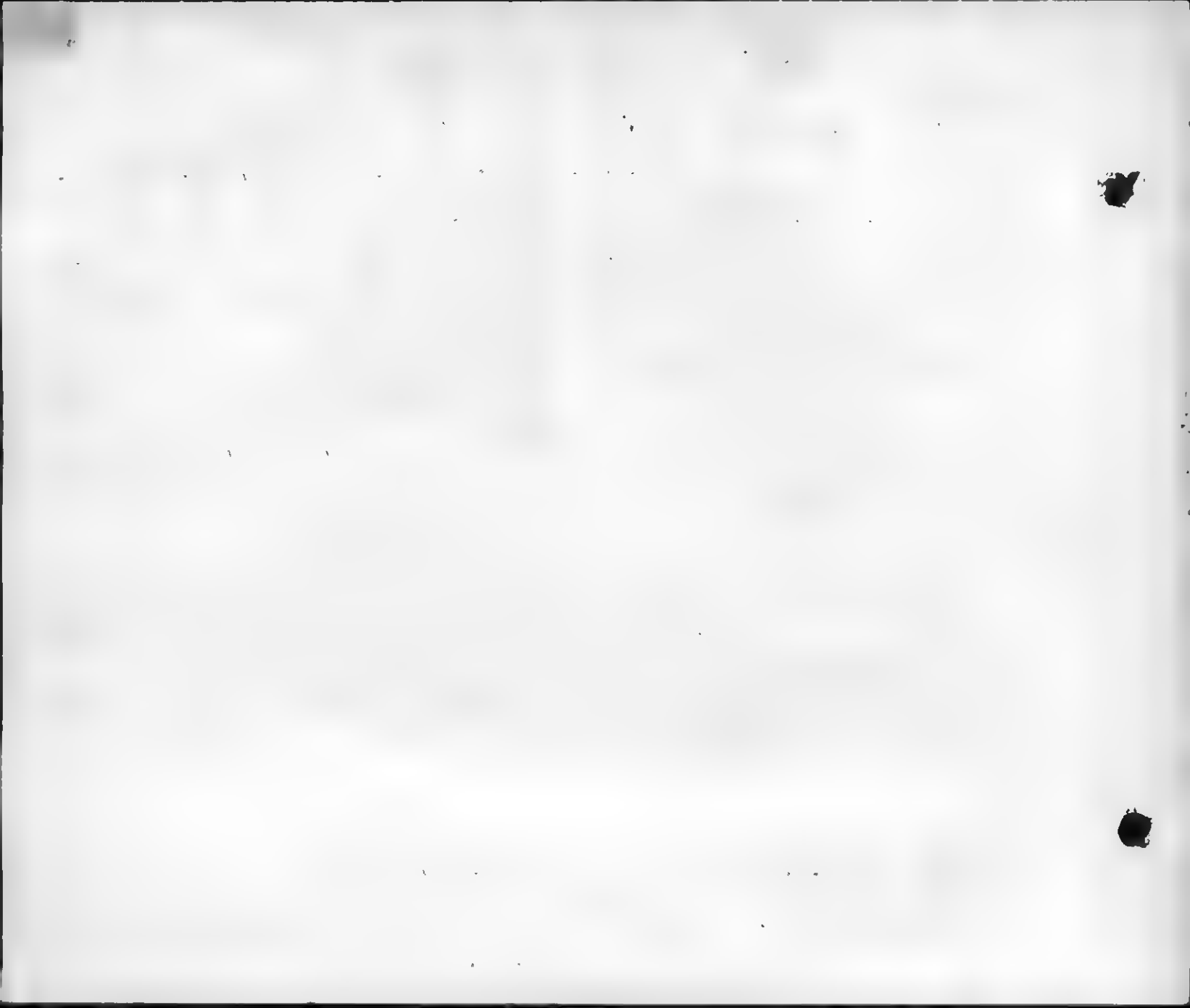
Reg. Dist. No.

03273

1. PLACE OF DEATH a. COUNTY Montgomery County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 47 hrs. 12 mins.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City, Maryland Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital		e. STREET ADDRESS 485 Maine Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Nancy Annette Hammond		4. DATE OF DEATH Month Day Year 3-15-1969							
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-59		9. AGE (In years last birthday) yrs 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Essie Louise Hammond							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records, Olney, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atalectasis DUE TO 160.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra cranial hemorrhage DUE TO (c) 2 days 2 days.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Breech Delivery									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from 3-13 , 19 59 , to 3-15 , 19 59 , that I last saw the deceased alive on 3-14 , 19 59 , and that death occurred at M , from the causes and on the date stated above ADDRESS (Street, city or town, state) Olney, Maryland DATE SIGNED 3-15-59									
ACTUAL SIGNATURE Rubel A. Yates		M.D. Dr. R.A. Yates							
PHYSICIAN'S NAME (Type) Dr. R.A. Yates		Olney, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/1959		22c. NAME OF CEMETERY OR CREMATORY Fuller Family Cemetery		22d. LOCATION (City, town, or county) (State) Pine Orchard Howard Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Easton Stone		ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

2073385XVS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3307

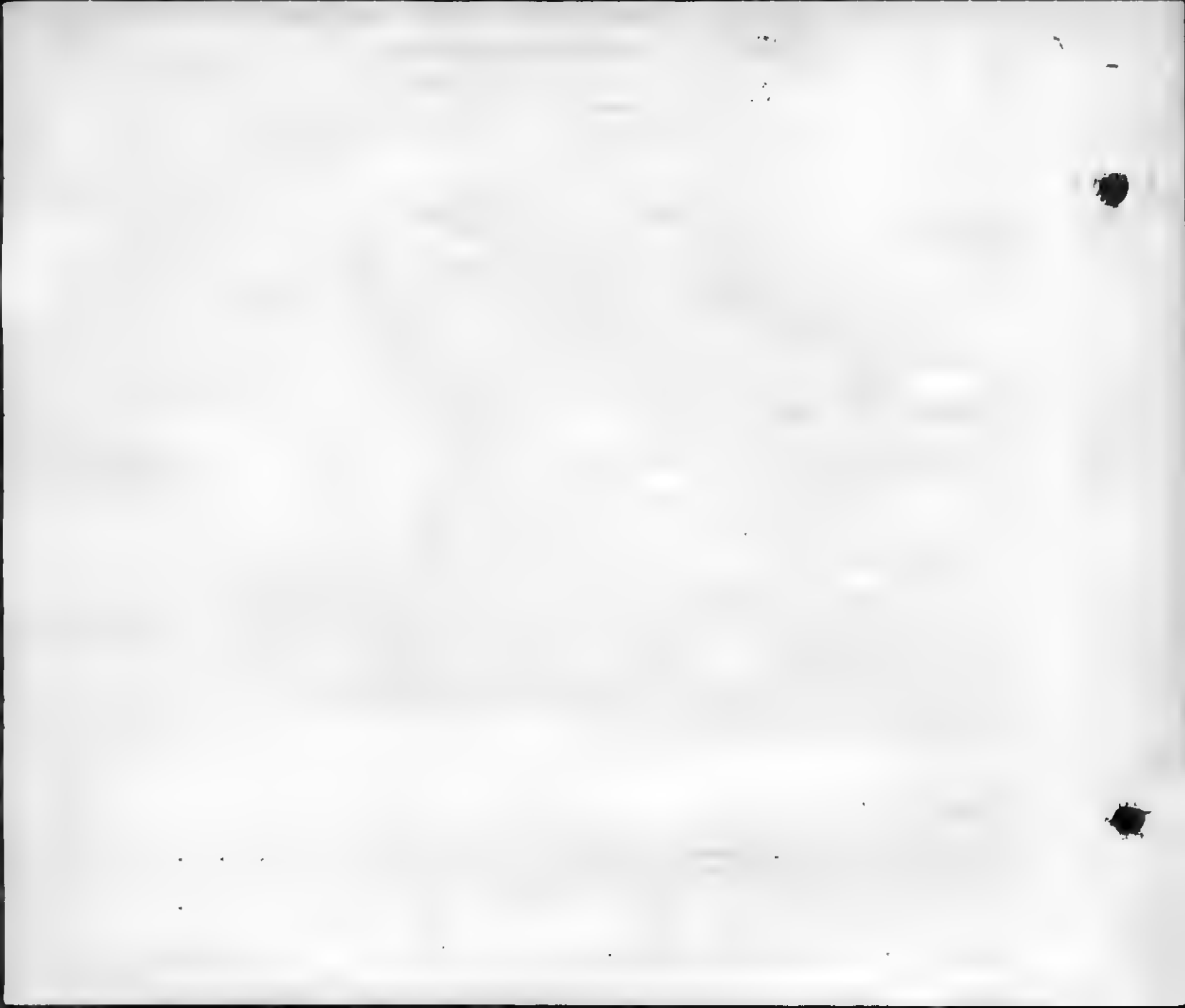
CERTIFICATE OF DEATH

03274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
c. LENGTH OF STAY IN 1b <u>2 days</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1d STREET ADDRESS <u>5525 Prospect St. Friendship Heights</u>			
3. NAME OF DECEASED (Type or print) <u>Wickard</u> First <u>Hearn</u> Middle <u>Hearn</u> Last				4. DATE OF DEATH <u>March 25</u> 19 <u>59</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 24 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired attorney Dept of Justice</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rufus D. Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth H. Hearn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Stefred A Hearn</u> Address <u>(over)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Trained cell tumor, adenocarcinoma gland</u> <u>4 d. 7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Anterior lobe of Pituitary Gland</u> DUE TO (c) <u>10 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9:30</u> 19 <u>58</u> , to <u>3:25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3:24</u> 19 <u>59</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip R. James</u>				ADDRESS (Street, city or town, state) <u>Washington Clinic D.C.</u> DATE SIGNED <u>3/25/59</u>			
PHYSICIAN'S NAME (Type) <u>Philip R. James</u>				Washington Clinic, D. C.			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edgehill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Charlestown, W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3. This certificate should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03275

Reg. Dist. No.

3308

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16			
c. LENGTH OF STAY IN 1b 4½ days				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Fred Middle H Last Heenan				4. DATE OF DEATH Month March Day 29 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/05	9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 23 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assist. Controller			10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph T. Heenan				14. MOTHER'S MAIDEN NAME Hattie Hicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. Yes-		17. INFORMANT Anne J. Heenan	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, posterior, acute DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 40 hours 16 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 20, 1959 to March 29, 1959 , that I last saw the deceased alive on March 28, 1959 , and that death occurred at 1 A M, from the causes and on the date stated above							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Robert N. Coale M.D. 4630 Montgomery Ave., Bethesda Md				3/31/59			
PHYSICIAN'S NAME (Type) ROBERT N. COALE, 4630 Montgomery Ave., Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.				24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



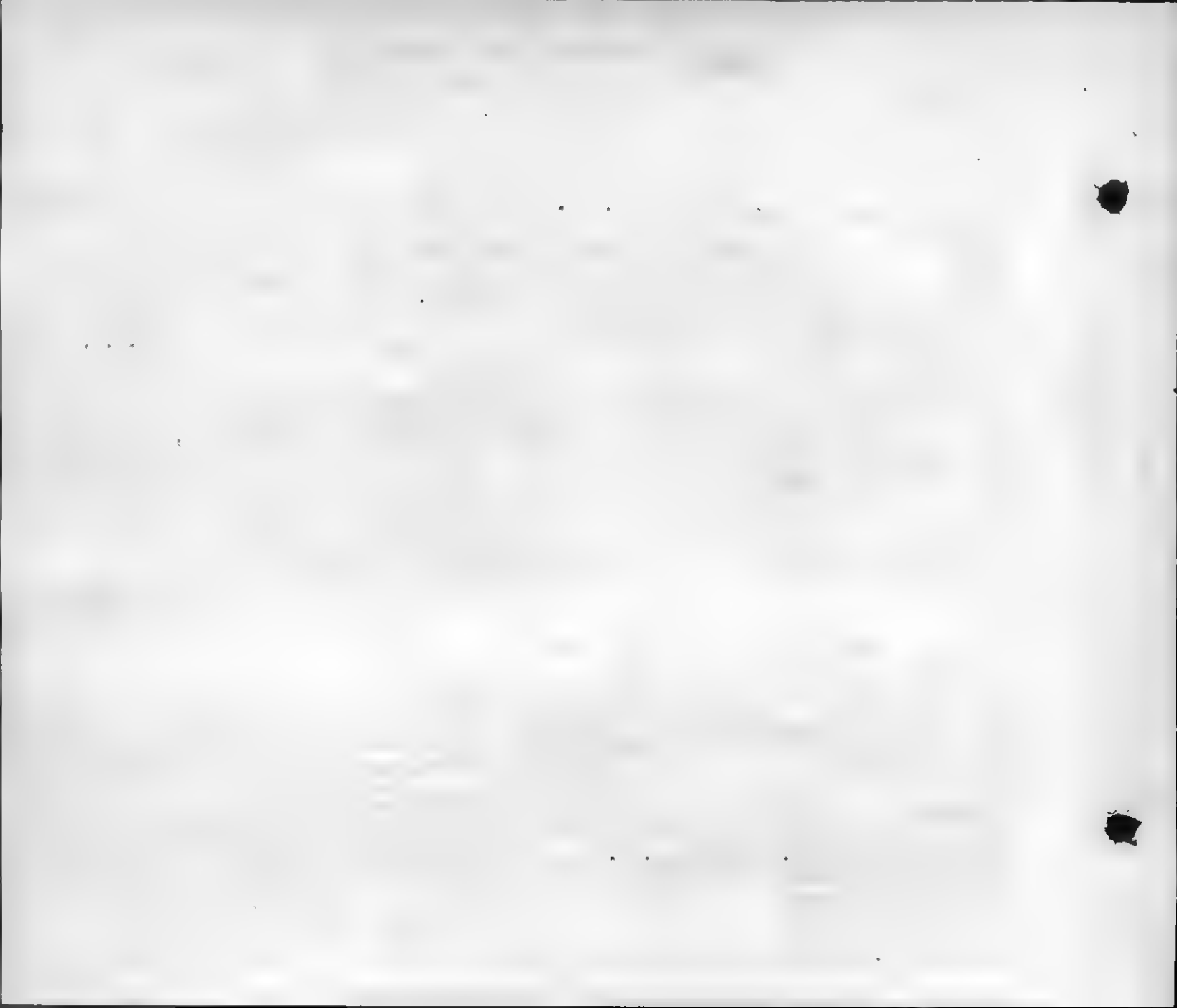
3300
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 15 days		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Colorado b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 2221 Lima Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Virginia Middle Belle Last Heidtbrink		4. DATE OF DEATH Month March Day 5 Year 19 59		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1926		9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 6 Days 24		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME John Pester				14. MOTHER'S MAIDEN NAME Ina Bishop													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE GENERALIZED PERITONITIS 173X DUE TO WITH SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MECHANICAL INTESTINAL OBSTRUCTION DUE TO METHOTREXATE TOXICITY (c) METASTATIC CHORIO CARCINOMA INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs. 24-48 hrs. 7 days 2 years																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from February 18, 19 59 , to March 5, 19 59 , that I last saw the deceased alive on March 5, 19 59 , and that death occurred at 5:50 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-5-59 ACTUAL SIGNATURE Donald A. Kellogg M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Donald A. Kellogg, M. D. Bethesda 14, Maryland																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3/6/59-		22c. NAME OF CEMETERY OR CREMATORY Fairmont Cemetery		22d. LOCATION (City, town, or county) (State) Denver, Colorado											
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3310

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 37 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2120 16th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Catherine (Kay) Marie Hendricks				4. DATE OF DEATH Month Day Year March 2, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 14, 1923	
9. AGE (In years lost birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Patrick McNerney				14. MOTHER'S MAIDEN NAME Sussane Meade			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 141-18-2644		17. INFORMATION The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic cirrhosis with esophageal varices from DUE TO portal hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) portal hypertension DUE TO (c) portal hypertension INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 24, 19 59 , to March 2, 19 59 , that I last saw the deceased alive on March 2, 19 59 , and that death occurred at 11:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-3-59 The National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Robert D. Bloodwell, M.D.		PHYSICIAN'S NAME (Type) Robert D. Bloodwell, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-59		22c. NAME OF CEMETERY OR CREMATORY mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Hanlon				ADDRESS 3831 Ga Ave NW		24a. REC'D BY REGISTRAR MAR 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



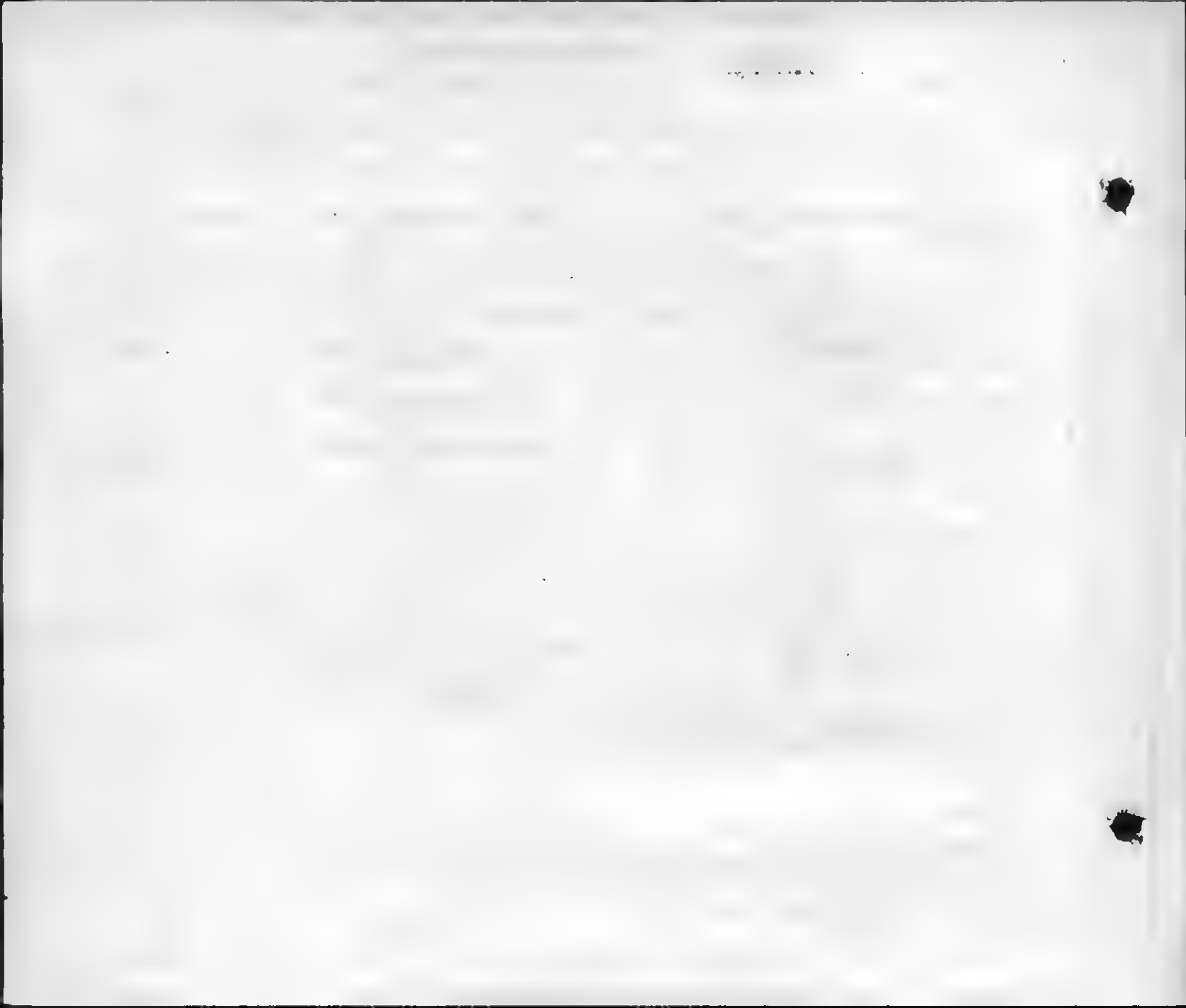
3311
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN				d. STREET ADDRESS 13014 FLACK ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE HEYN				4. DATE OF DEATH Month Day Year MARCH 27 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/80	
				9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Monee, Illinois	
13. FATHER'S NAME Isidore Heyn				14. MOTHER'S MAIDEN NAME Henrietta Blum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 323-09-7310		17. INFORMANT Henry Raden (nephew)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 586X DUE TO Hepatic carcinoma							1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abstinence DUE TO (c) Post-operative infection							8
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o m p m Month 19 Day 19 Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) SILVER SPRING, MD		(County) (State)	
21. I certify that I attended the deceased from Jan 19 59 to Mar 27 19 59 , that I last saw the deceased alive on 25 March 19 59 , and that death occurred at 6:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 13014 FLACK ST. SILVER SPRING, MD			
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED Mar 30 59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-27-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Tree House of Israel		22d. LOCATION (City, town, or county) (State) Chicago Ill	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				24a. REC'D BY REGISTRAR Mar 30 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03279

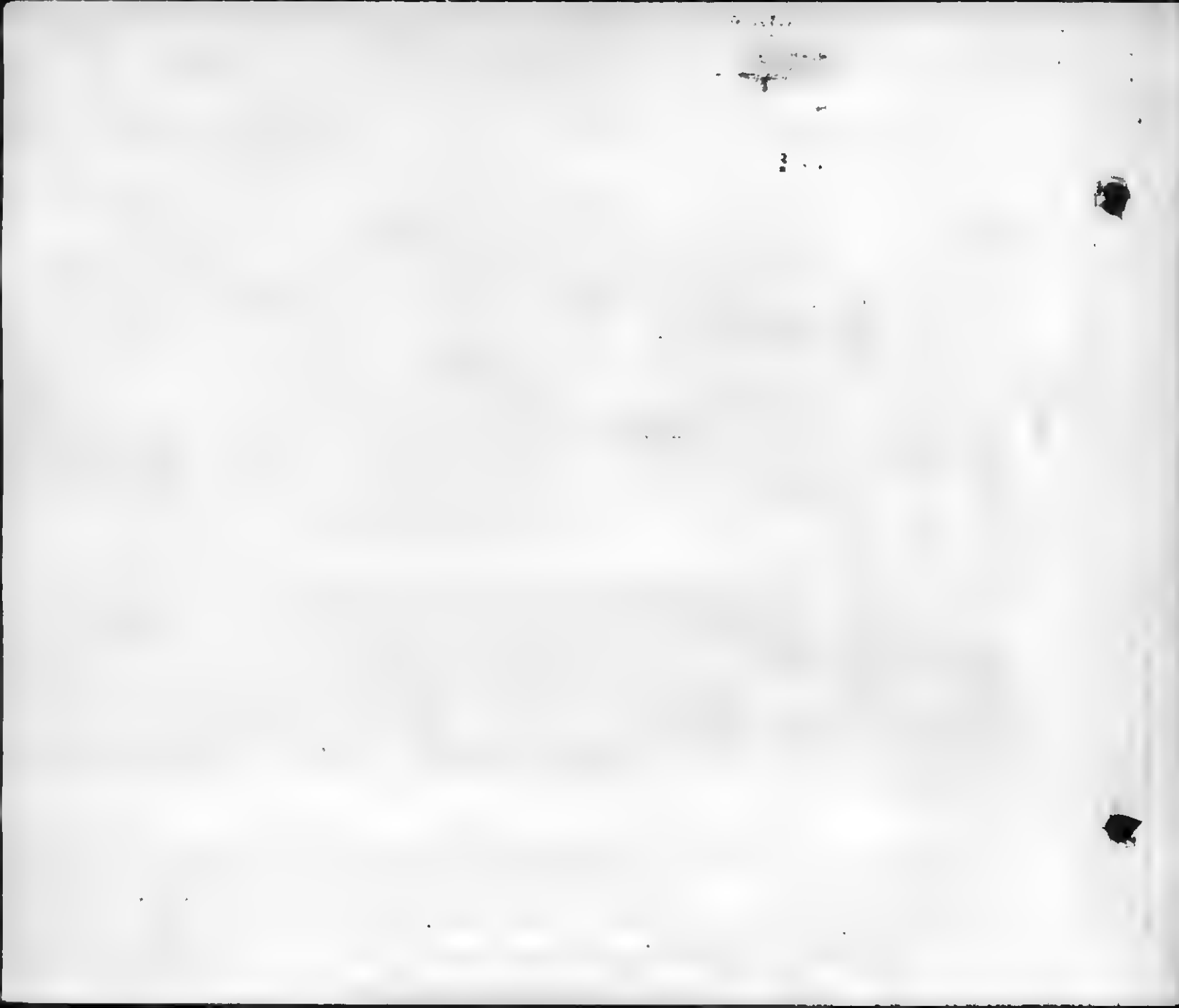
Reg. Dist. No.

3228

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>79 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>602 Pershing Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Sophie Hillerman</u>				4. DATE OF DEATH Month Day Year <u>3 - 25 - 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-13-98</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O RR.</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>August Schetzer</u>				14. MOTHER'S MAIDEN NAME <u>Louise Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>712-10-8785</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastasis to Bones of Pelvic Girdle</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5, 1945</u> to <u>March 25, 1959</u> , that I last saw the deceased alive on <u>March 24, 1959</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Wardrop MD</u> M.D. <u>837 Bonfret St. Silver Spring</u>				DATE SIGNED <u>3/25/59</u>			
PHYSICIAN'S NAME (Type) <u>W. B. WARDROP MD</u>				ADDRESS (Street, city or town, state) <u>837 Bonfret St. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wardrop & Simpson</u>				ADDRESS <u>Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	
24a. REC'D BY REGISTRAR <u>Mar 30 '59</u>				DATE			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



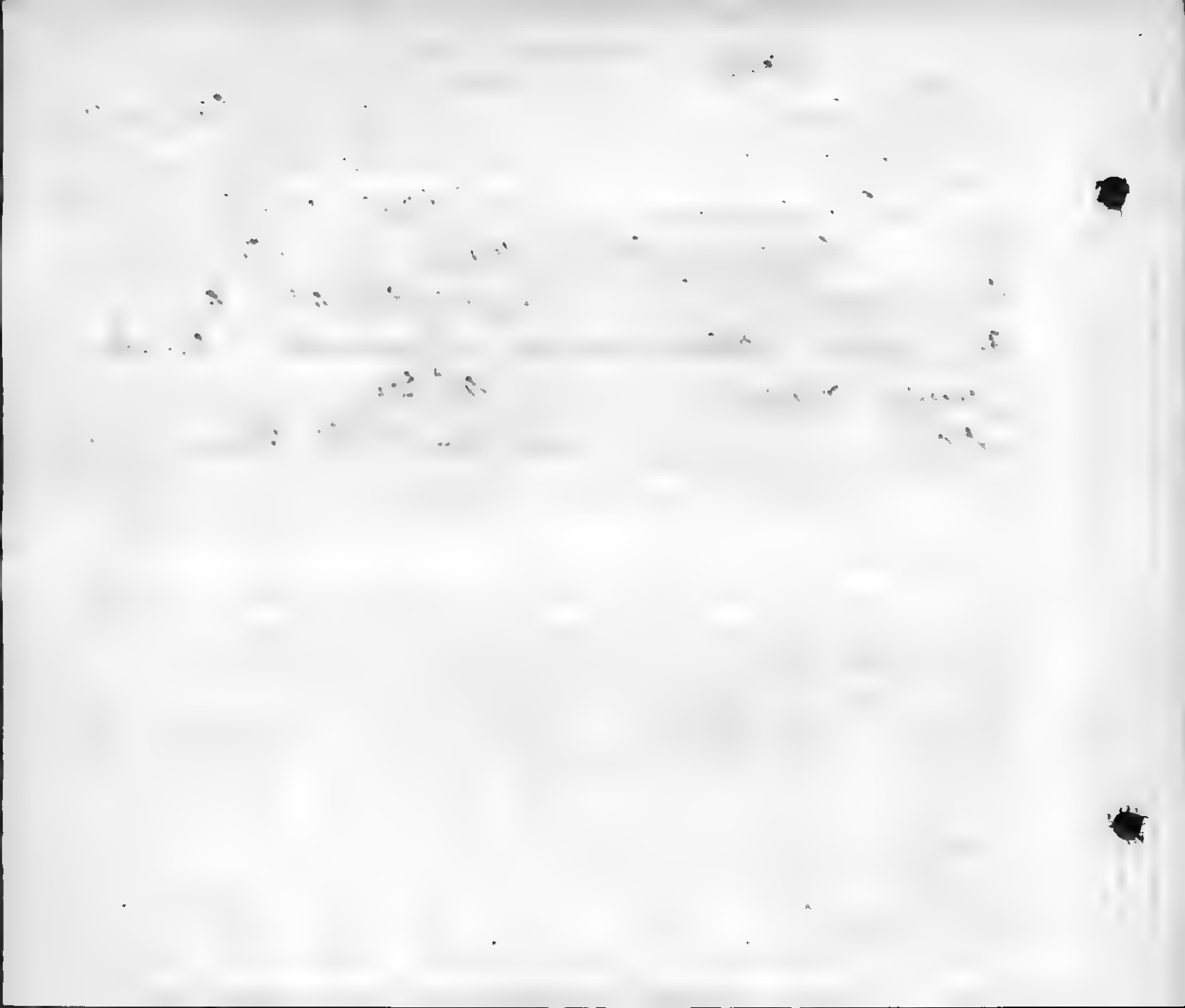
3312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		1. d. STREET ADDRESS <u>1319 Hayes Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Francis</u> Last <u>Hines</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1915</u>
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Assoc. of Iron Workers</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hines</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McKeown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>YES</u>	
17. INFORMANT <u>Wife Anna Rita Hines</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> <u>467.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Irreversible Shock</u> DUE TO (c) <u>Retroperitoneal Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u> <u>8 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status Post-Laminectomy</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February, 1958</u> to <u>March 19, 1959</u> , that I last saw the deceased alive on <u>March 19, 1959</u> , and that death occurred at <u>8:25 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.		ADDRESS (Street, city or town, state) <u>8248 Georgia Ave</u> DATE SIGNED <u>3/20/59</u>	
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>		<u>Silver Spring</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Piska</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Brand</u>

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remain carbon paper, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03281

3313
CERTIFICATE OF DEATH

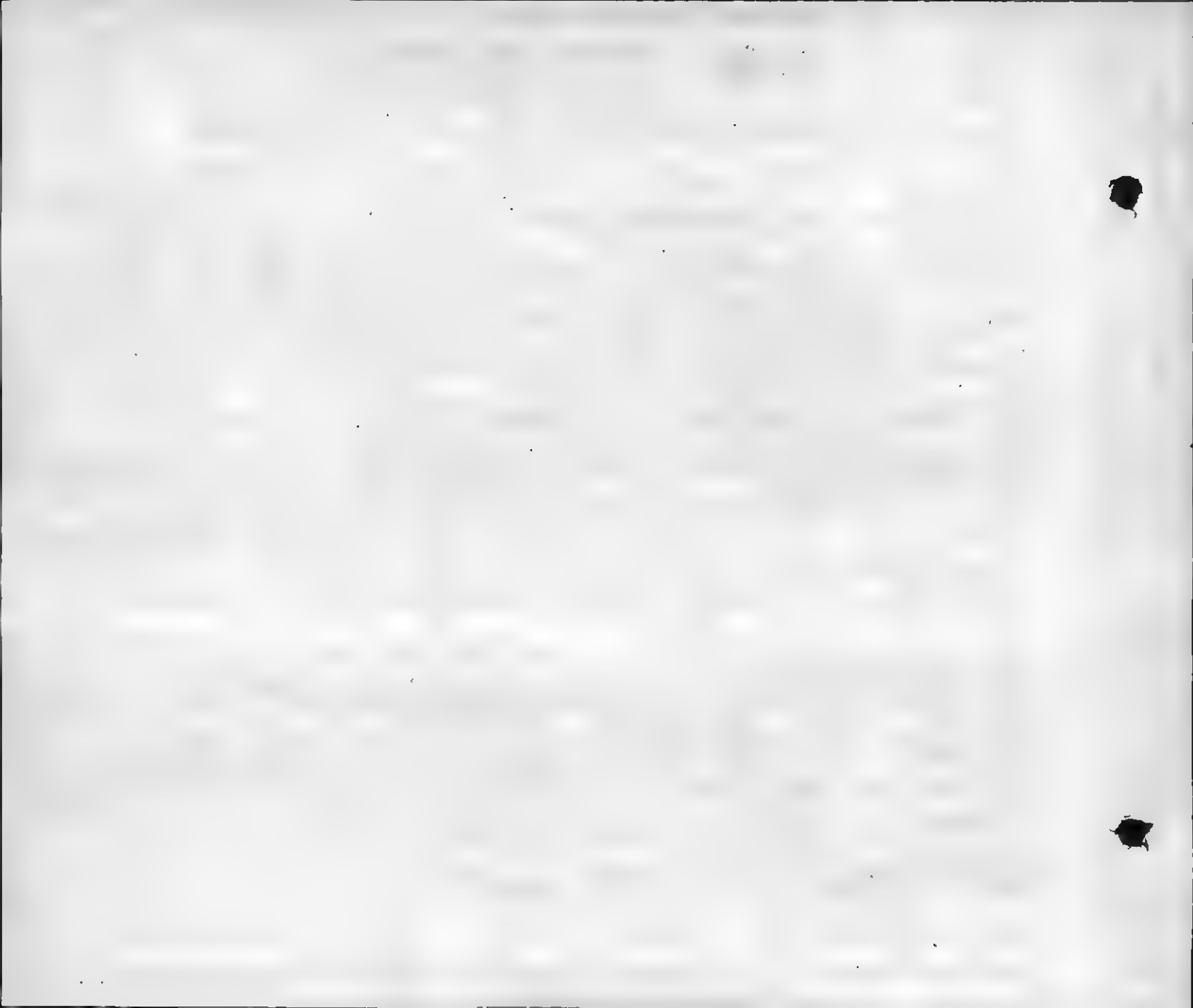
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 4 in.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stoke Grove Chronic Hospital</u>		d. STREET ADDRESS <u>703 Elder St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>H.</u> Last <u>Hollenbach</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Haffon</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide S. Steed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Miss Rosalee Haffon</u> Address <u>703 Elder St. N.W. Wash. D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>3 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-6</u> , 19 <u>59</u> , to <u>3-6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-6</u> , 19 <u>59</u> , and that death occurred at <u>7:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lillian K. Ziegler M.D.</u>		ADDRESS (Street, city or town, state) <u>Colney, Ind.</u>	
PHYSICIAN'S NAME (Type) <u>Lillian K. Ziegler</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>MARCH 8, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CHURCH CEM</u>	22d. LOCATION (City, town, or county) (State) <u>BROAD CREEK, IND.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Ziegler</u>		ADDRESS <u>1254 CARROLL ST. N.W.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3314

CERTIFICATE OF DEATH

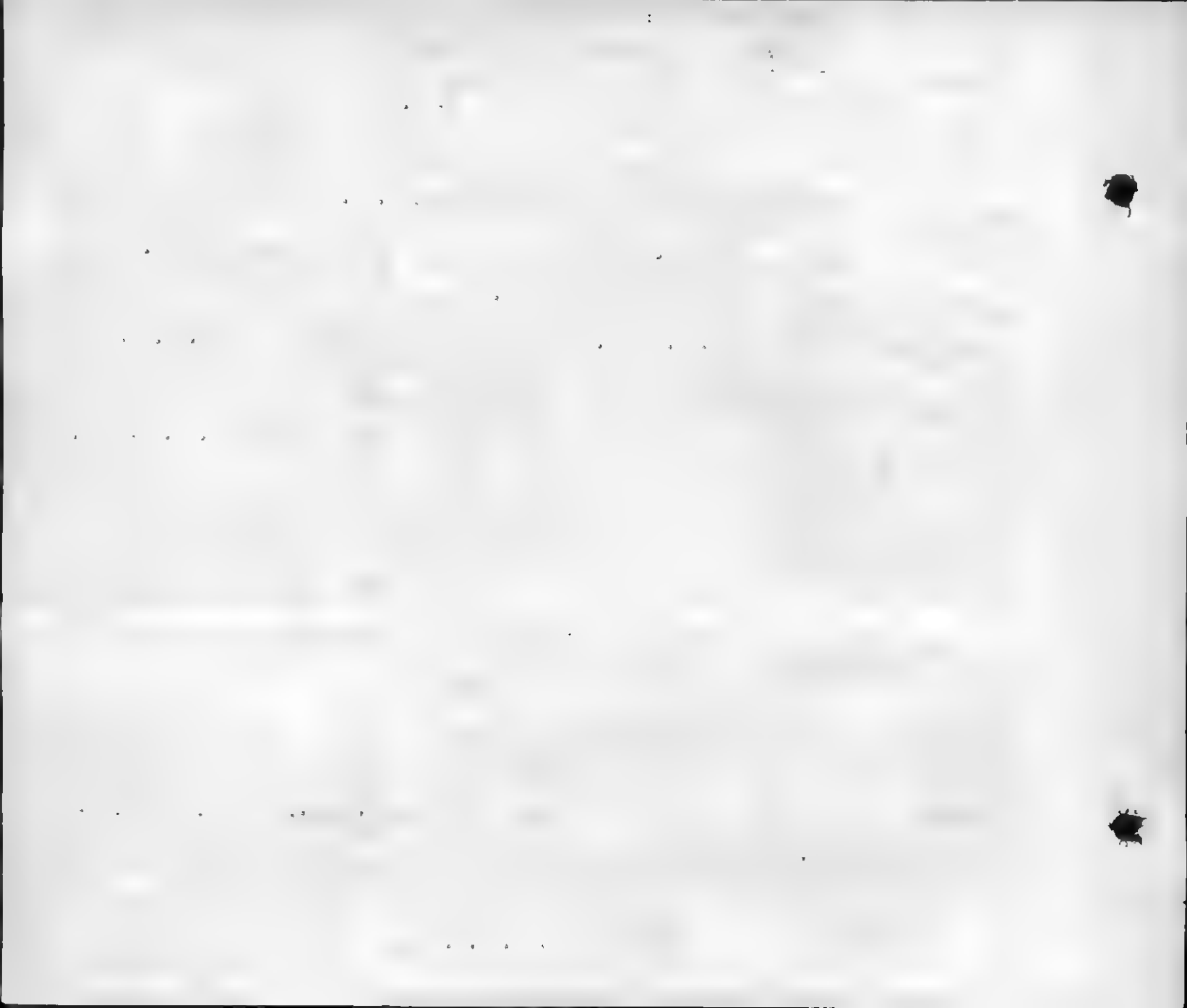
03282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 1820 M St., N. W.	
3. NAME OF DECEASED (Type or print) First Zelma Middle E. Last Holmes		4. DATE OF DEATH Month March Day 8th. Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23rd. 1904
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Simpsonville, Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Bickerstaff		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Oliver W. Holmes		Address 1820 M St. N. W., D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Hypertension			INTERVAL BETWEEN ONSET AND DEATH 9 wks. 6 mo 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 19 54 , to March 8 , 19 58 , that I last saw the deceased alive on March 8 , 19 58 , and that death occurred at 3:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2150 Penn. Ave., N. W., Wash., D. C. DATE SIGNED ACTUAL SIGNATURE Paul N. Taylor M D PHYSICIAN'S NAME (Type) Paul N. Taylor			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/11/59	
22c. NAME OF CEMETERY OR CREMATORY Baptist Church Cemetery		22d. LOCATION (City, town, or county) (State) Simpsonville, Texas.	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. F. Birch's Sons		24a. REC'D BY REGISTRAR DATE MAR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



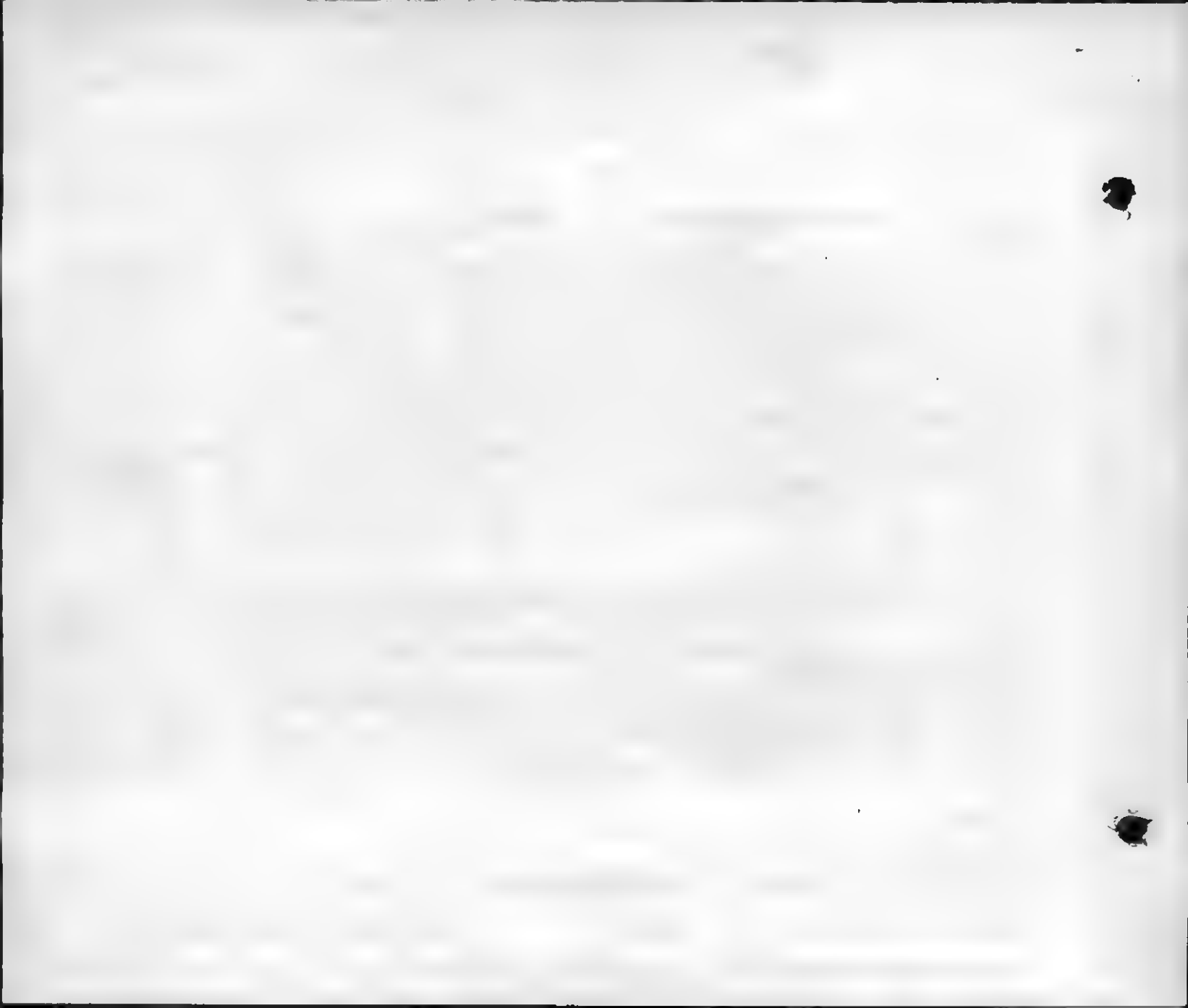
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 7 Film 239 3-9-59 3315 CERTIFICATE OF DEATH

03283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo, Md.</u>			
c. LENGTH OF STAY IN 1b <u>1 yr.</u>				d. STREET ADDRESS <u>312 W. Hawthorne Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Vincent's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Holt</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gardening</u>			
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. Holt</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Elsie Thompson</u> Address <u>Kentland, Md. 7621 Kilmer St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Brain Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 6, 1956</u> , to <u>March 6, 1957</u> , that I last saw the deceased alive on <u>March 5, 1957</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Stuart Lydman</u> M.D. <u>3006 E. St. N.W. Wash. D.C.</u>				DATE SIGNED <u>3/7/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Natl. Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. L. ...</u> ADDRESS <u>3072 - M St. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	



3229

CERTIFICATE OF DEATH

Reg. Dist. No.

03284

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TEKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TEKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8500 FLOWER AVE.</u>				d. STREET ADDRESS <u>8500 FLOWER AVE</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Isabel TALBERT Holtman</u>				4. DATE OF DEATH Month Day Year <u>MARCH 9 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 5, 1866</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>TOBIAS TALBERT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH PERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>WILLIAM J. HOLTMAN 4000 MASS AVE.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO <u>Severe Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>January 1955</u> to <u>9 March 1959</u> , that I last saw the deceased alive on <u>3 March 1959</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8801 Coleville Road, Silver Spring, Md.</u> DATE SIGNED <u>9 March '59</u>							
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.				PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/12/59</u>		<u>ROCKCREEK</u>		<u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Local Funeral Home</u>				ADDRESS <u>4812 9th Ave., NW</u>		24a REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
				24b REGISTRAR'S SIGNATURE <u>Cirius L. Kraw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1-10-1942

3316

CERTIFICATE OF DEATH

Reg. Dist. No.

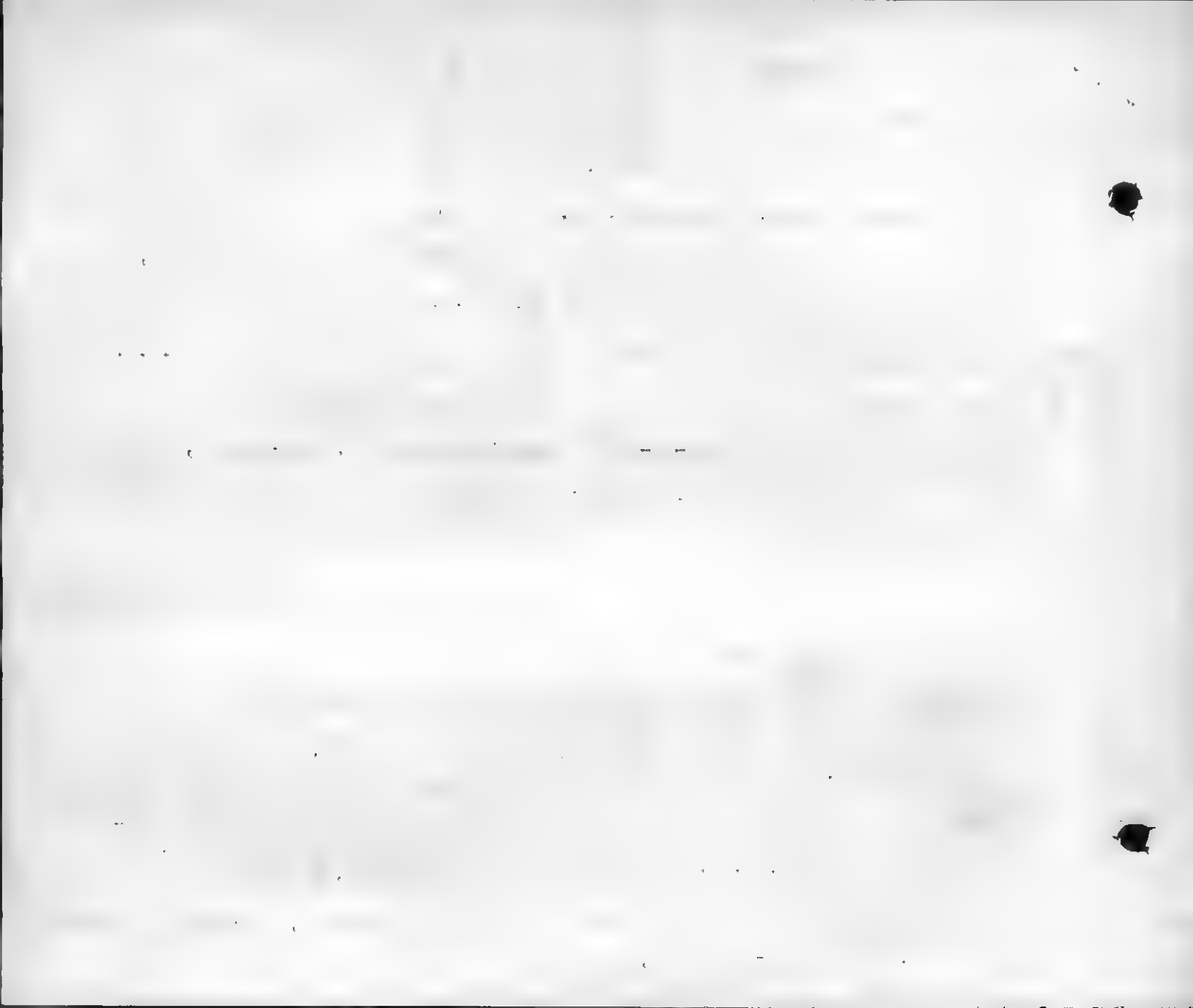
03285

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY (In 1b) 137 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Colorado b. COUNTY Sedalia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 445 d. STREET ADDRESS (none) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Karl Last Homeyer		4. DATE OF DEATH Month March Day 6, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1907
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 2 Hours 15 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resort Operator		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Emil Homeyer	
14. MOTHER'S MAIDEN NAME Helen Schlichting		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 564-34-5056		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adrenal Cortical Carcinoma 170.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1958 to March 6, 1959 , that I last saw the deceased alive on March 6, 1959 , and that death occurred at 12:35 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-6-59	
ACTUAL SIGNATURE Jack Levin M.D. Jack Levin, M. D.		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/7/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 9 '59	
24b. REGISTRAR'S SIGNATURE William S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03281

Reg. Dist. No.

3317

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colony</u>		c. LENGTH OF STAY IN TB <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg Co. Gen Hosp</u>				d. STREET ADDRESS <u>Damascus</u>			
3. NAME OF DECEASED (Type or print) First <u>Willard</u> Middle <u>Honeycutt</u> Last <u>Honeycutt</u>				4. DATE OF DEATH Month <u>mar</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-09</u>	9. AGE (In years last birthday) <u>50</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>19</u> Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Building</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ruth Honeycutt</u>				14. MOTHER'S MAIDEN NAME <u>Sally Honeycutt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>410-09-3468</u>		17. INFORMANT <u>Ronnie Honeycutt (son)</u> Address <u>Damascus, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO <u>Fracture of skull</u> Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull</u> (c) <u>Fracture of skull</u> (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushed chest</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car involved in auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> with <u>p.m.</u> <u>3-7</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD R-134</u>		20f. (City or town) <u>Dr. Woodfield Montg</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharon Baptist</u>		22d. LOCATION (City, town, or county) <u>Cooksville, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mobawther</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>MAR 11 '59</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3318

CERTIFICATE OF DEATH

03287

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARTLAND				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANY HILLS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3814 WINDY LANE</u>				d. STREET ADDRESS <u>4106 111. AVE. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>LINWOOD P. HOSLEY</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 9, 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min _____		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>	
12. CITIZEN OF WHAT COUNTRY? _____				13. FATHER'S NAME <u>COLUMBUS P. HOSLEY</u>			
14. MOTHER'S MAIDEN NAME <u>BESSIE BODGE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			
16. SOCIAL SECURITY NO. _____				17. INFORMANT Address <u>BARBARA B HOSLEY 4106 111. AVE. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with metastases</u> 177X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary heart Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Jan 27, 1944</u> to <u>Mar 30, 1959</u> that I last saw the deceased alive on <u>Mar 30, 1959</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Harvitz</u> M.D.				ADDRESS (Street, city or town, state) <u>4201 New Hampshire NW</u> DATE SIGNED <u>3/30/59</u>			
PHYSICIAN'S NAME (Type) _____				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>4-1-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>			
22d. LOCATION (City, town, or county) <u>SMITHLAND</u> (State) <u>MD</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 The Ave NW</u>			
24a. REC'D BY REGISTRAR <u>APR 6 59</u> DATE				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Board</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



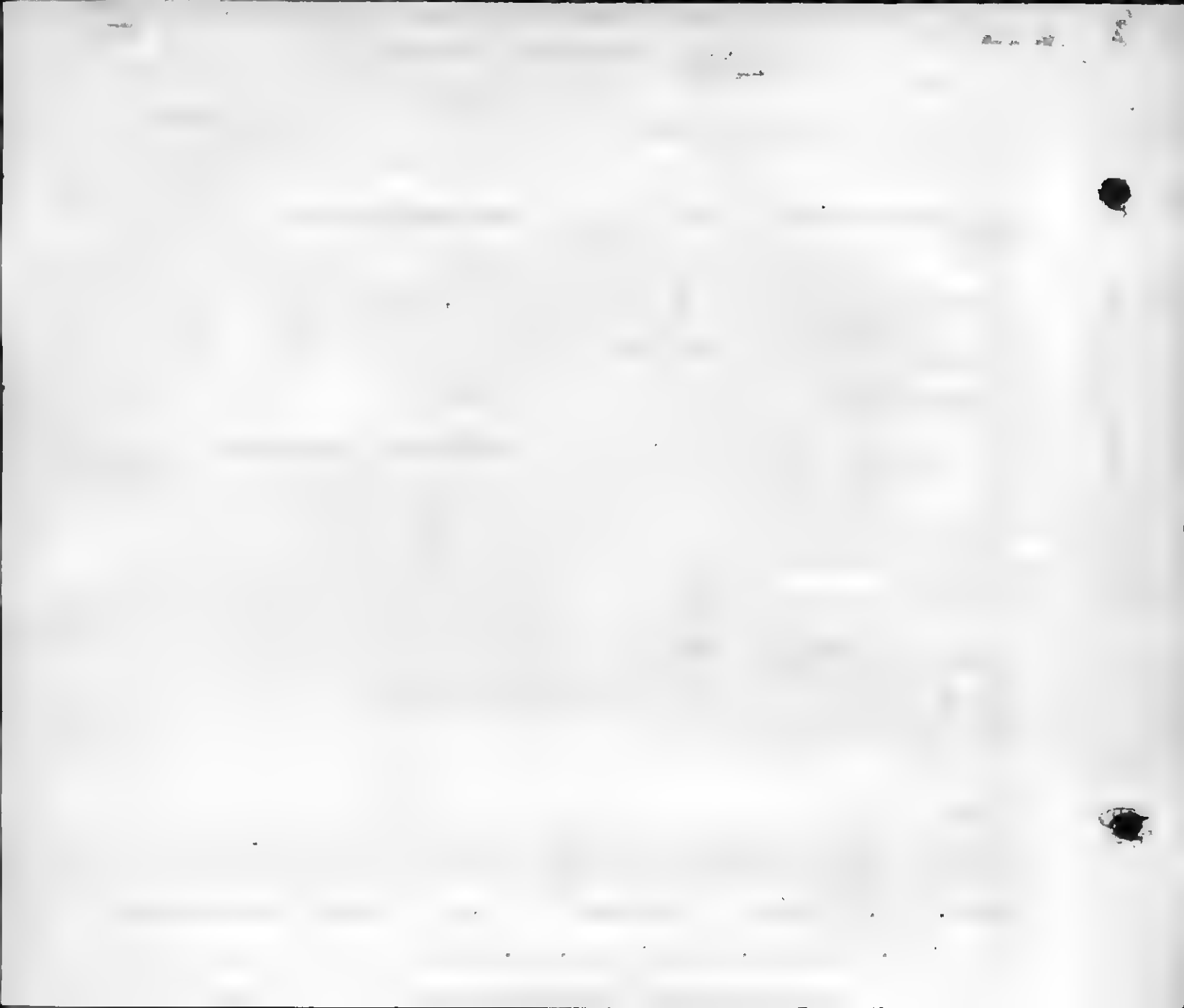
3319 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MARYLAND Montgomery		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8205 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle HUBER Last HUBER		4. DATE OF DEATH Month MARCH Day 22 Year 1959	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 9 Days 19	11. IF UNDER 24 HRS Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11 BIRTHPLACE (State or foreign country) Ohio
12 CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Bernard Koch	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Dorothy McKinley-Item Address 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Senility, (89 years of age)		INTERVAL BETWEEN ONSET AND DEATH 2+ days 10+ years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart Pericarditis (viral) 22 Dec. 1958		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from 1957 , 19 present , to present , that I last saw the deceased alive on 3/21 , 19 59 , and that death occurred at 10:55 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 4890 BATTERY LA DATE SIGNED 3/22/59			
ACTUAL SIGNATURE Charles J. Savarise Jr. M.D.		PHYSICIAN'S NAME (Type) CHARLES J. SAVARISE JR. BETHESDA 14 MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. Bur.	22b. DATE THEREOF 3/23/59	22c. NAME OF CEMETERY OR CREMATORY Evergreen	22d. LOCATION (City town or county) (State) South Gate, Kentucky
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR DATE MAR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03289

3320

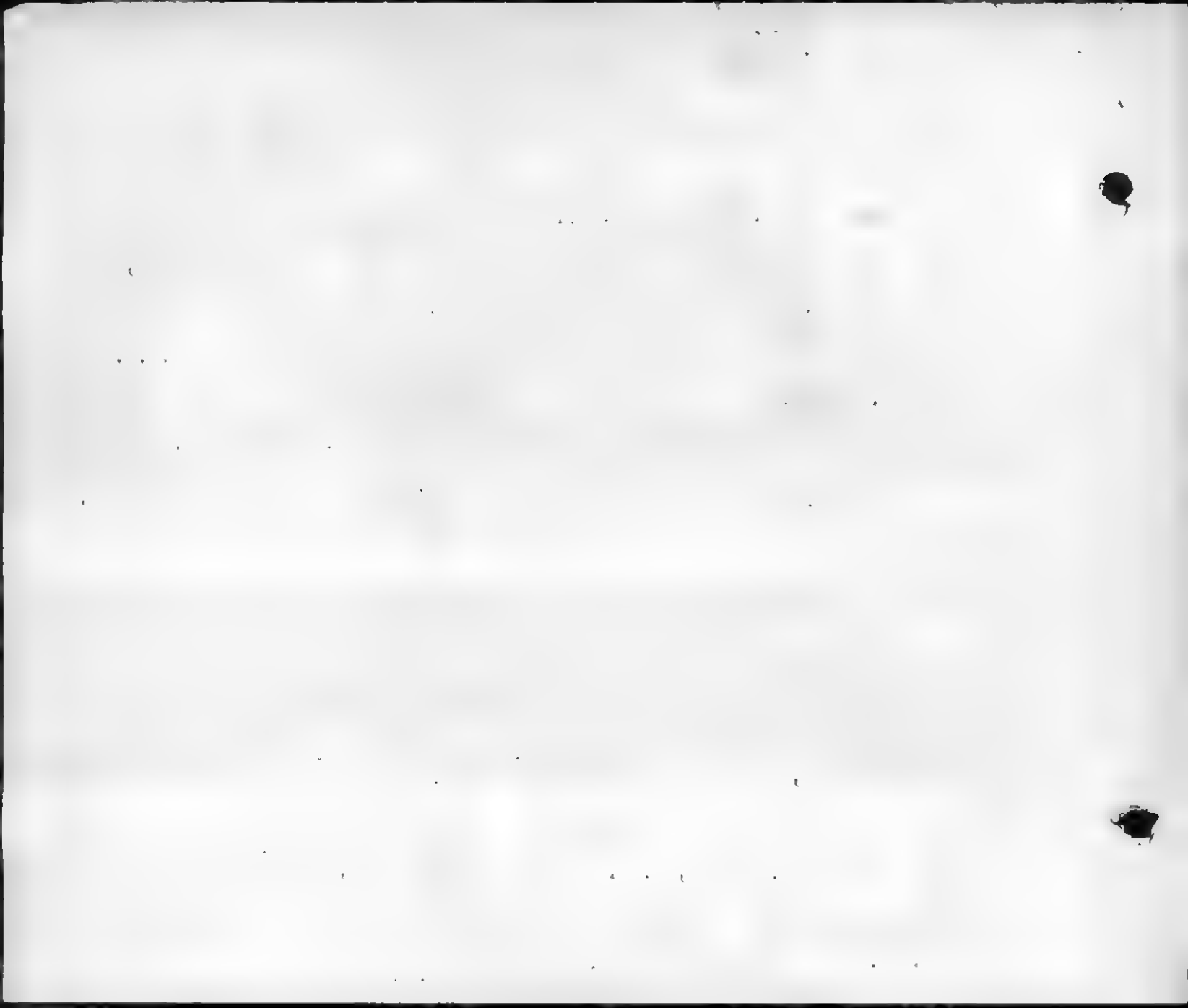
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN IB 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk d. STREET ADDRESS 1802 Graney Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Twohy Hudgins		4. DATE OF DEATH Month Day Year March 17, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 15, 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Contracting	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME William J. Hudgins	
14. MOTHER'S MAIDEN NAME Maggie Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Positive Coccal Septicaemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myelogenous leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 26, 1959 , to March 17, 1959 , that I last saw the deceased alive on March 17, 1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3/18/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
ACTUAL SIGNATURE Nathan S. Taylor, M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-20-59	22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	22d. LOCATION (City, town, or county) (State) Norfolk, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robt. A. Pumphrey		24a. REC'D BY REGISTRAR Bethesda, Maryland	24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

Reg. Dist. No.

03290

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 WINDSOR STREET		d. STREET ADDRESS 424 WINDSOR STREET	
3. NAME OF DECEASED (Type or print) First MIDDLE Last CARROLL EDWARD HUMPHREY		4. DATE OF DEATH Month MARCH Day 22 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1914
9. AGE (In years last birthday) 48 45 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scientist		10b. KIND OF BUSINESS OR INDUSTRY John Hopkins Lab.	
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HORACE G. HUMPHREY, SR.		14. MOTHER'S MAIDEN NAME ESTELLE CARROLL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 11	
17. INFORMANT Mrs. Virginia A. Humphrey, 424 Windsor St.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, to The present, 1959, that I last saw the deceased alive on March 17, 1959, and that death occurred at 10:30 AM, from the causes and on the date stated above. 3/22/59 ADDRESS (Street, city or town, state) DATE SIGNED J. M. Evans M.D. 901 23rd St. N.W., Washington, D.C.			
ACTUAL SIGNATURE J. M. EVANS			
PHYSICIAN'S NAME (Type) J. M. EVANS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/25/59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Humphrey, Inc.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE MAR 24 '59		Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3322

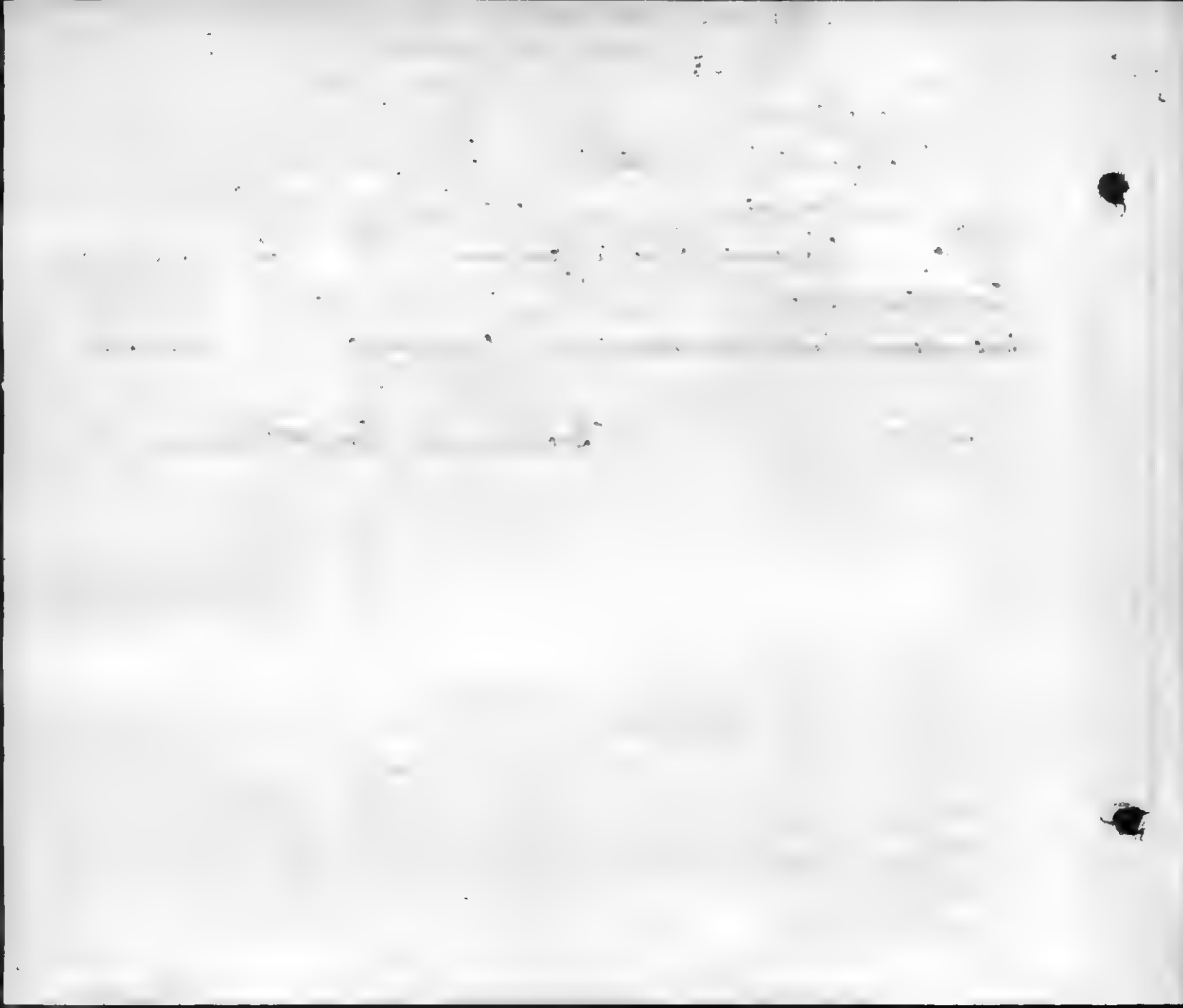
CERTIFICATE OF DEATH

Reg. Dist. No.

03291

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN IB <u>5 days</u>				d. STREET ADDRESS <u>18617 Garfield St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Corneia</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 2, 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed - invalid for many years</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>4. S. A.</u>	
13. FATHER'S NAME <u>Irving Christopher Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Florence E. Ellett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u>None</u>				17. INFORMANT <u>Brother-in-law Everett E. Brown</u> Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO (c) <u>arterio-sclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2+ days</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>100.0</u> <u>Tuberculosis pulmonary old inactive</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 19, 1959</u> , to <u>3/20, 1959</u> , that I last saw the deceased alive on <u>3/20/59</u> 19 <u> </u> , and that death occurred at <u>4:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savant</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Bittern Lane Bethesda, Md.</u>			
DATE SIGNED <u>3/24/59</u>							
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVANT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>3-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery.</u>		22d. LOCATION (City, town, or county) (State) <u>Charlottesville, Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3323 **CERTIFICATE OF DEATH**

03292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 15</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4417 Stanford St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Viola Johnson</u>				4. DATE OF DEATH Month Day Year <u>March 8 1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practitioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Cox</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Ann Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-96485</u>		17. INFORMANT <u>Cherry Chase, Md.</u> Address <u>4417 Stanford St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Toxemia - Peritonitis</u> DUE TO (c) <u>Acute cholecystitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
						<u>5-7 days</u>	
						<u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> , 19 <u>59</u> , to <u>3/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>59</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter Atkinson</u>				ADDRESS (Street, city or town, state) <u>1835 Eye St. N.W.</u>		DATE SIGNED <u>3/8/59</u>	
PHYSICIAN'S NAME (Type) <u>WALTER ATKINSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Washington - Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. B...</u> ADDRESS <u>1661 Good Hope Rd SE Wash. DC</u>				24a. REC'D BY REGISTRAR <u>APR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03293

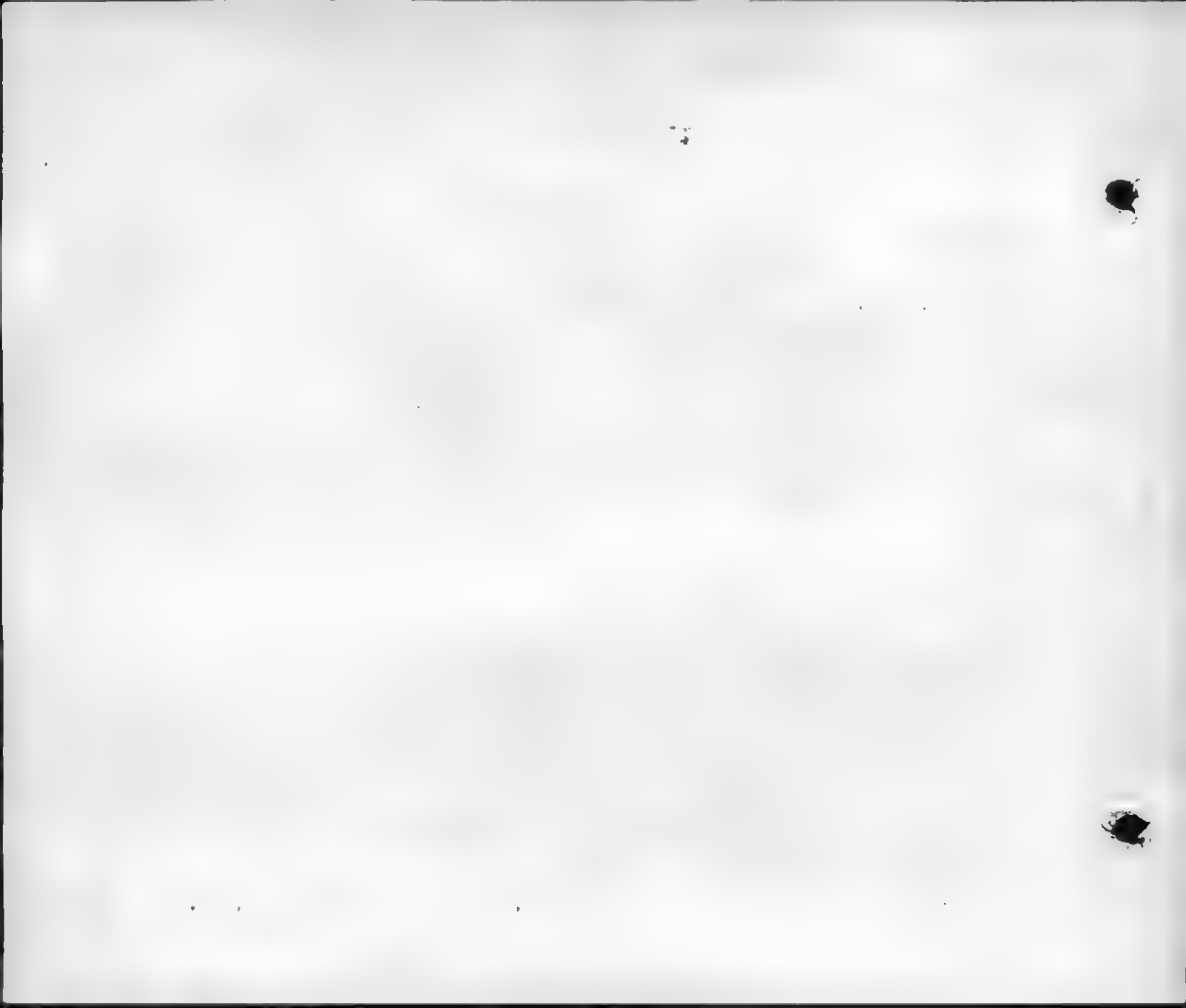
3324

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blair</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring - R.F.D. #</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Co. Gen. Hosp</u>			d. STREET ADDRESS <u>Stewart Lane</u>		
3. NAME OF DECEASED (Type or print) <u>Michael Claude Jones</u>			4. DATE OF DEATH Month <u>mar</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-58</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	9. AGE (in years last birthday) <u>0</u> yrs. <u>4</u> Months <u>21</u> Days		
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Walter Jones</u>			14. MOTHER'S MAIDEN NAME <u>Frances Poge</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-11-58</u>	17. INFORMANT <u>Frances Jones (mother) Steen 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Aspiration of stomach contents</u> DUE TO (c) <u>Broncho-pneumonia</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Rockville, Md.</u>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosenz</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-8-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosenz</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swodden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Hume</u>

4266XV5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3325

CERTIFICATE OF DEATH

03294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suburban Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4167 Cottage Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD C JONES</u>		4. DATE OF DEATH <u>March 11 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Driver Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. K. Jones</u>		14. MOTHER'S MAIDEN NAME <u>MARY (J. K. Jones)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>878-03-4134</u>	
17. INFORMANT <u>Lucy Jones</u> Address <u>4167 Cottage Terrace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myocardial infarction</u> 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>March 11, 1959</u> , that I last saw the deceased alive on <u>March 11, 1959</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul N. Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>2150 Pa. Ave. N.W.</u> DATE SIGNED <u>March 11, 1959</u>	
PHYSICIAN'S NAME (Type) <u>PAUL N. TAYLOR M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT CROFT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>Riv. Md.</u>		24a. REC'D BY REGISTRAR <u>W.A.S.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>



3230

CERTIFICATE OF DEATH

Reg. Dist. No.

03295

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital 22 Manchester Pl.</u>				d. STREET ADDRESS <u>Silver Silver</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes Wilhemina Justus</u>				4. DATE OF DEATH Month Day Year <u>Mar-6 14 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-17-95</u>		9. AGE (In years last birthday) <u>64 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Latvia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. America</u>	
13. FATHER'S NAME <u>Peter Michelson</u>				14. MOTHER'S MAIDEN NAME <u>Maria Kleinschmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Pt's Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, massive, fatal</u>							<u>1-2-1-1-3</u>
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>complete heart block</u>							<u>5-1-1-3</u>
(c) <u>see list of other causes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> , to <u>1959</u> , that I last saw the deceased alive on <u>3/13</u> , 1959, and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Marshall Cuvillier, Jr.</u>							
PHYSICIAN'S NAME (Type) <u>L. MARSHALL CUVILLIER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond G. Bishop</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3231

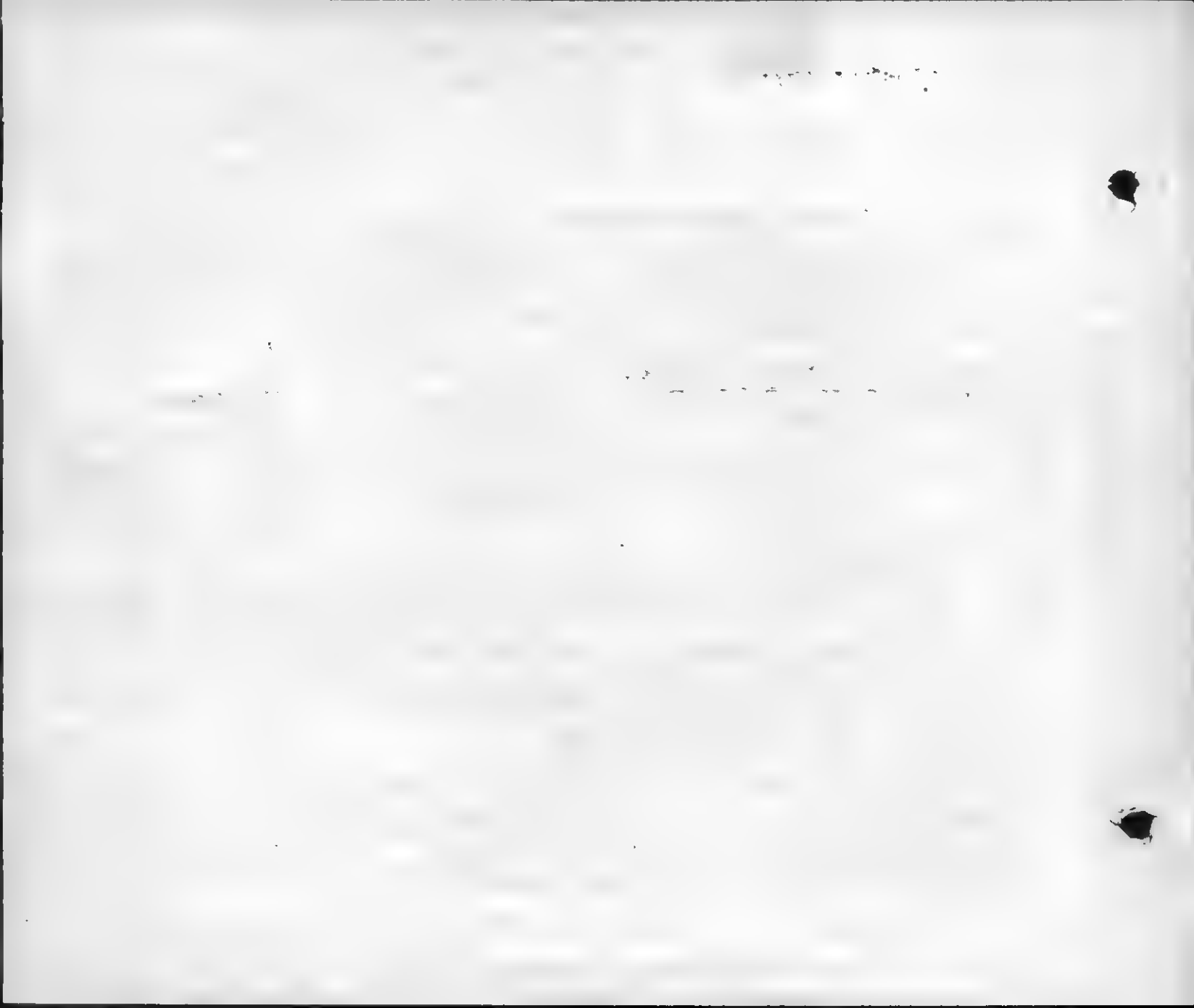
CERTIFICATE OF DEATH

03296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 - Sycamore Ave. Nursing Home</u>		d. STREET ADDRESS <u>2901 - 26th E</u>	
3. NAME OF DECEASED (Type or print) <u>Laura A. Kantz</u>		4. DATE OF DEATH <u>March 1 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1864</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. F UNDER 1 YEAR IF UNDER 24 Hrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Penn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William H. Kantz</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Myrta Ann E. Kantz</u>		Address <u>2451 Myrtle Ave NE Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>163X</u> DUE TO (b) <u>Cancer of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Or metastasis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2/25/59</u> <u>Jan 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/21/59</u> to <u>3/1/59</u> , that I last saw the deceased alive on <u>2/24/59</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u> DATE SIGNED <u>3/1/59</u>	
ACTUAL SIGNATURE <u>H. T. Morse</u> M.D.			
PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03297

3326

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac c. LENGTH OF STAY IN 1b 26 Rockville		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last William A. KENNEY		4 DATE OF DEATH Month Day Year March 25, 19 59		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 20, 1871	
9 AGE (In years last birthday) 87 yrs		10 IF UNDER 1 YEAR Months Days Hours Min. 11 5		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Capitol Trans.		
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes		
INFORMANT Orria T. Kenney - Item #2		Address		
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Infarction 300x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 12 hrs 36 hrs Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Pneumonia & Bronchitis & old TBC				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/1/53 to 3/25/59 , that I last saw the deceased alive on 3/25/59 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md DATE SIGNED 3/25/59				
ACTUAL SIGNATURE Stephen N. Jones M.D.		22. LOCATION (City, town, or county) (State) Gaithersburg, Maryland		
PHYSICIAN'S NAME (Type) Stephen N. Jones		22a. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		
22b. DATE THEREOF 3-25-59		22c. LOCATION (City, town, or county) (State) Gaithersburg, Maryland		
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey - Bethesda 14, Md.		24a. REC'D BY REGISTRAR MAR 30 '59		
24b. REGISTRAR'S SIGNATURE Arthur L. House				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03298

3232

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700 HUDSON AVENUE		d. STREET ADDRESS 3515 T. STREET, N. W.	
3. NAME OF DECEASED (Type or print) Elizabeth		4. DATE OF DEATH March 6 1959	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOV'T.	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN I. KING		14. MOTHER'S MAIDEN NAME ELIZA J. WESTERMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT EVENTIDE NURSING HOME RECORDS—Same as D		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis of the Heart Disease DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 yrs 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3:25 p. m. 3-16-59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-12 , 19 58 , to 3-16 , 19 59 , that I last saw the deceased alive on 2-12-3 , 19 59 , and that death occurred at 3:25 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James Edward Fitzgerald		ADDRESS (Street, city or town, state) 5415 Conn. Ave. N.W. Wash. 15, D.C.	
PHYSICIAN'S NAME (Type) Dr. James Edward Fitzgerald		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-9-59	22c. NAME OF CEMETERY OR CREMATORY HOLY ROOD CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Francis G. Collins		24a. REC'D BY REGISTRAR MAR 9 '59	
ADDRESS 3821-14 55th St. N.W. Wash. D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

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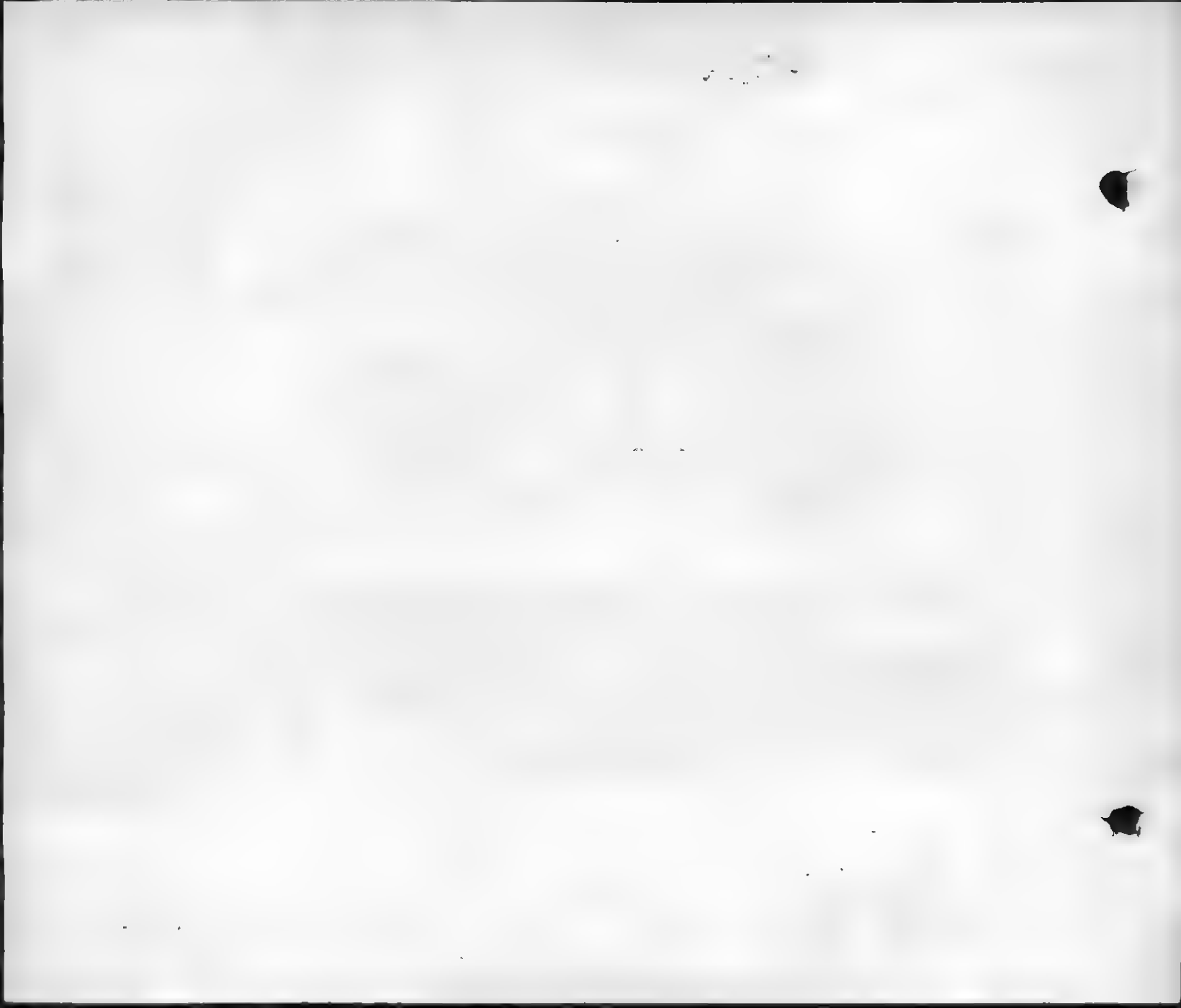
FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>D</u> Last <u>King</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Li</u>	7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Delany King</u>		14. MOTHER'S MAIDEN NAME <u>Sydney Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-10-9516</u>	
17. INFORMANT <u>Mr. Gust Muehlisch (daughter)</u>		Address <u>Damascus Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage + laceration</u> X X X X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Runner in auto involved in accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a.m. <u>3-7</u> p.m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mr Woodfield Montg Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Breschatt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Breschatt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Upper Seneca Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Mckown</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03300

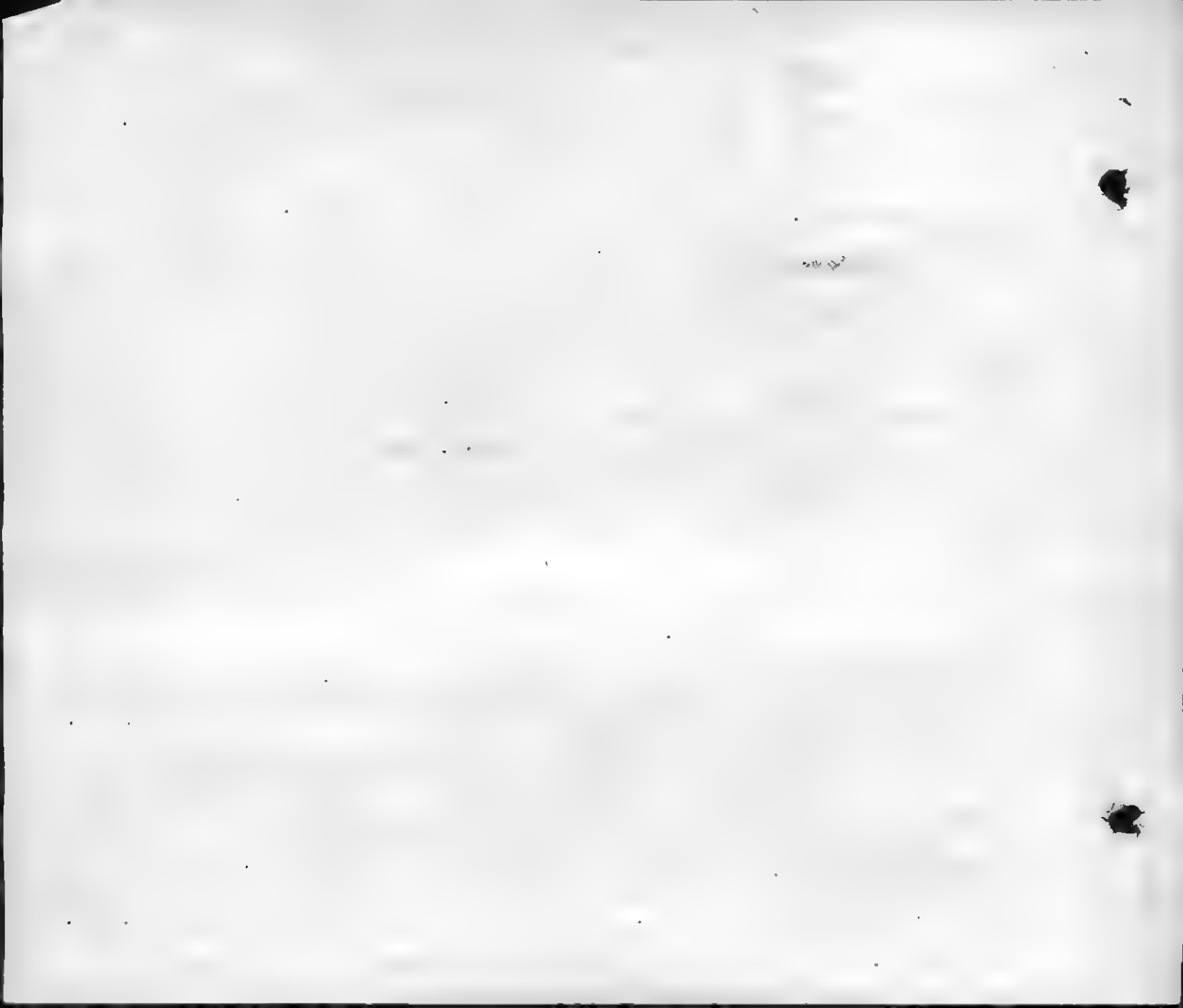
FOR STATE
HEALTH DEPT.

3328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If Institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>908 Viers Mill Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>			
3. NAME OF DECEASED (Type or print) <u>Stauzy. L King</u>		4. DATE OF DEATH <u>Mar 21, 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1888</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>10</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Singleton King</u>		14. MOTHER'S MAIDEN NAME <u>Mary Burdette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-1131</u>	
17. INFORMANT <u>Irene E. King-wife-same as 2d</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Right Lung</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture Right Hip</u> (c) <u>9 day</u> stalling the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor at home fracturing rt. hip</u>	
20c. TIME OF INJURY Hour <u>8:30</u> p. m. <u>3/12/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Rockville</u> (County) <u>Montg.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>3/22/59</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) <u>Prince George Co.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

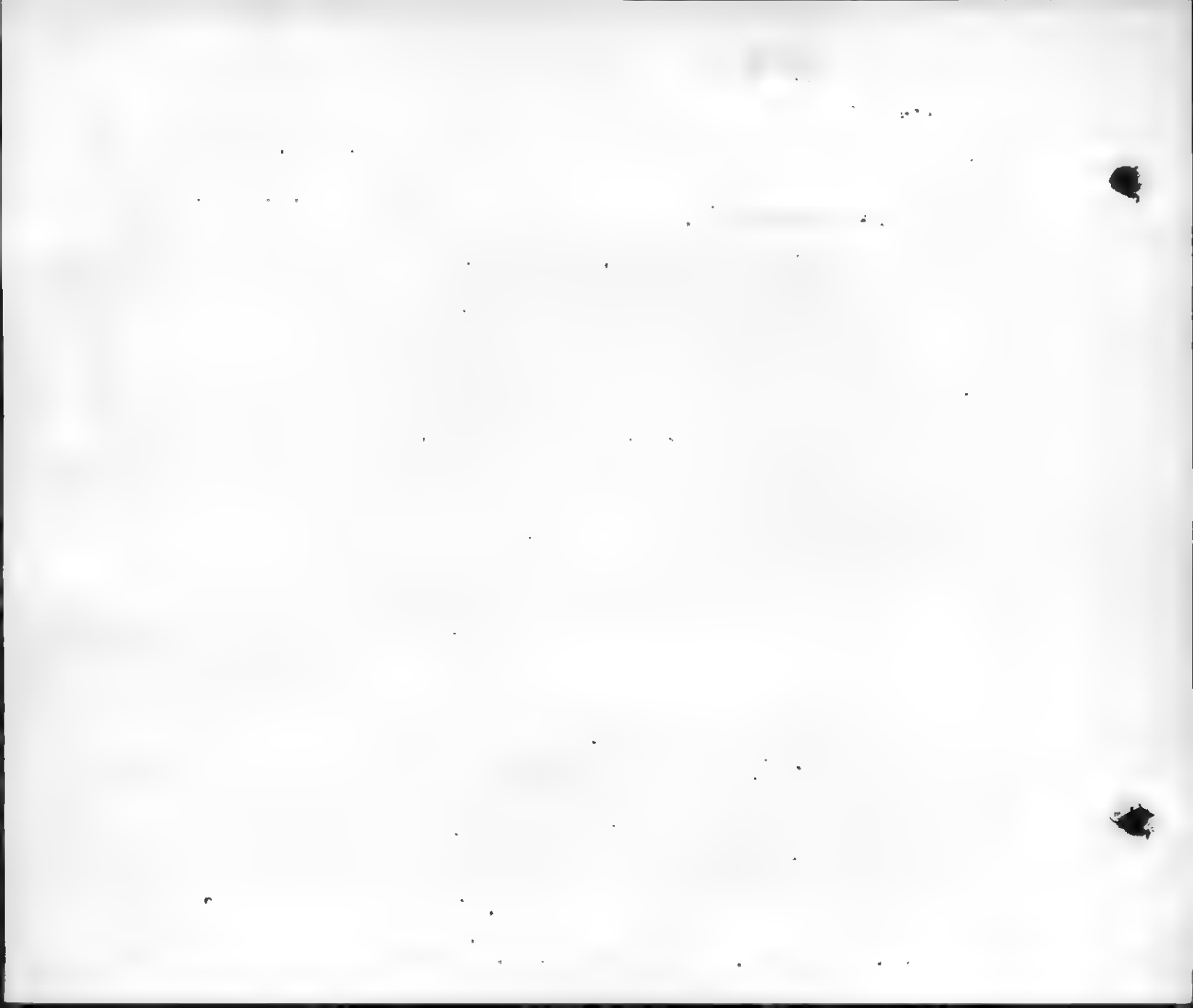


3329

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Nursing Home 14511 Colesville R.		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 3500 14th St. N.W. Apt. 412 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First GEORGE Middle A. Last KRAFT		4. DATE OF DEATH Month 2 Day 13 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/90
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Kraft		14. MOTHER'S MAIDEN NAME Julia Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 361-03-8383	
17. INFORMANT Charles C. Schmidt		Address same as #2	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331x DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) hypertension DUE TO hypertension (c) coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 2-3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spontaneous		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26, 1948 to March 13, 1957 that I last saw the deceased alive on 2-13-57 , and that death occurred at 3:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers M.D.		ADDRESS (Street, city or town, state) 1919 14th St. N.W. Washington 9, D.C. DATE SIGNED 3-13-57	
PHYSICIAN'S NAME (Type) John S. Rogers			
22a. BURIAL, CREMATION, REMOVAL. (Specify) Burial	22b. DATE THEREOF 3/17/1959	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C. DATE MAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>2 mo. 3 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp</u>		d. STREET ADDRESS <u>4800 Topping Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Albert F. Kunze</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAN AMERICAN Union</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert F. Kunze</u>		14. MOTHER'S MAIDEN NAME <u>Kathenka Faderlein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>4502 Adrien St - Rockville Md</u>	
17. INFORMANT <u>Mr. Albert C. Kunz</u>		18. ADDRESS <u>4502 Adrien St - Rockville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>		<u>18 months</u>	
331X DUE TO		<u>5 years</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Cerebral arteriosclerosis + hypertension</u>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Chronic pyelonephritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 1957, to <u>March</u> , 1959, that I last saw the deceased alive on <u>March 8</u> , 1959, and that death occurred at <u>7:35 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal</u>		DATE SIGNED <u>3/10/59</u>	
PHYSICIAN'S NAME (Type) <u>SYDNEY LEVENTHAL</u>		ADDRESS (Street, city or town, state) <u>9210 Columbia Rd, Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>March 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>for David S. Leventhal</u>		ADDRESS <u>1214</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



3331

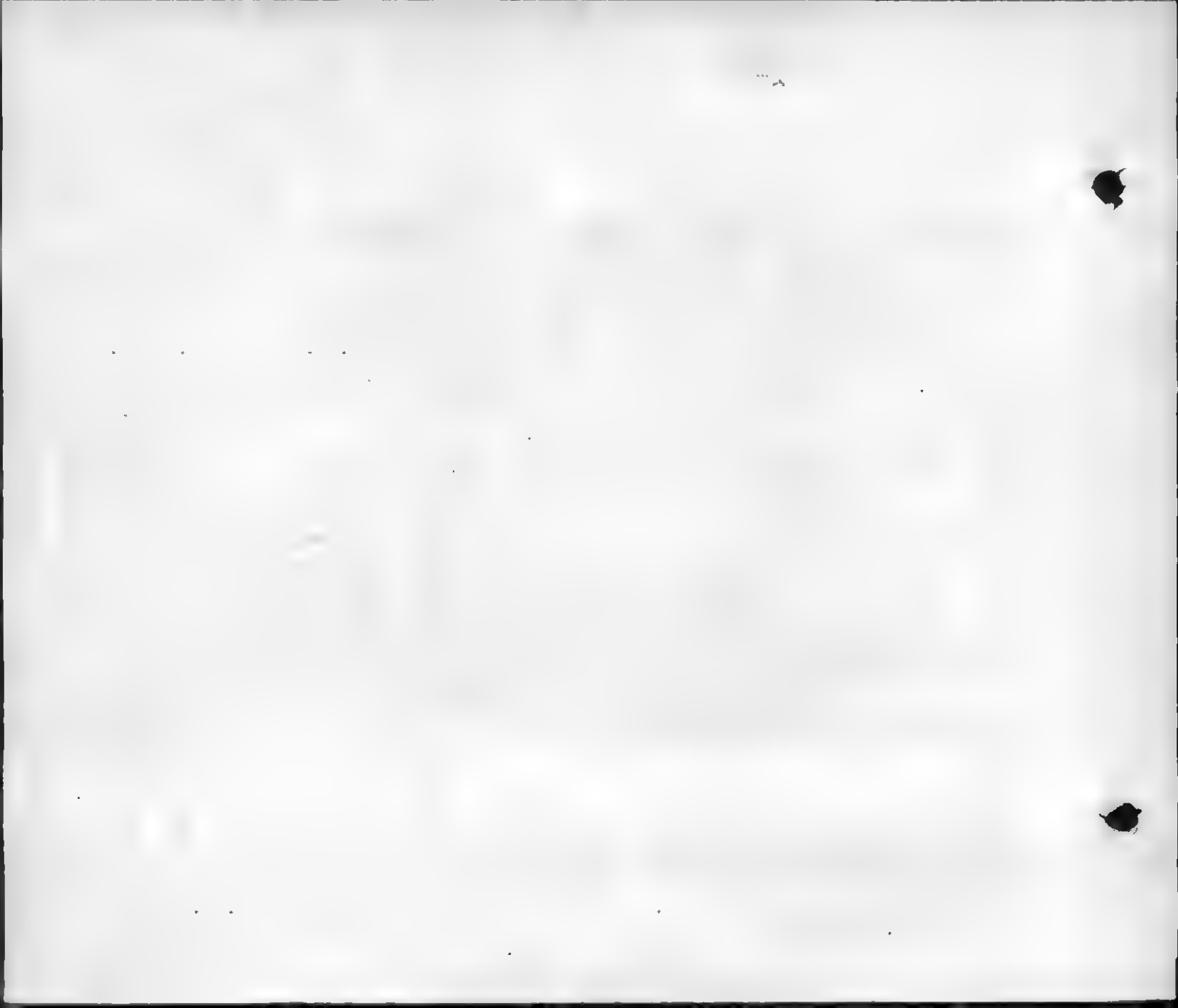
CERTIFICATE OF DEATH

03303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN b 5 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		d. STREET ADDRESS 10,554 METROPOLITAN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPHIN E THERESA LANGLEY		First JOSEPHIN		Middle E		Last LANGLEY		4. DATE OF DEATH Month March		Day 1		Year 1959	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 31, 1890		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR: Months 68		IF UNDER 24 HRS: Days 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY				10b. KIND OF BUSINESS OR INDUSTRY CLOTHING STORE				11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN J. LANGLEY				14. MOTHER'S MAIDEN NAME CATHERINE O'BRIAN									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT KENSINGTON, MD. MRS. GLADYS LYNCH 10554 METROPOLITAN AVENUE							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MARCH 1				20f. (City or town) SILVER SPRING		20g. (County) MD.	
21. I certify that I attended the deceased from Feb 16, 1959 , to Feb 25, 1959 , that I last saw the deceased alive on Feb 25, 1959 , and that death occurred at 6 a M., from the causes and on the date stated above.													
ACTUAL SIGNATURE John N. Andrews				ADDRESS (Street, city or town, state) 960 Coleville Rd Silver Spring									
PHYSICIAN'S NAME (Type) John N. Andrews				DATE SIGNED 3-1-59									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF MARCH 4, 1959		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY				22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pomphrey, Inc.						ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3332

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 yrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u>		b. COUNTY <u>montg</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>5325 Yorktown Rd. Wash 16, D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5325 Yorktown Rd. Wash 16, D.C.</u>		d. STREET ADDRESS		4. DATE OF DEATH Month <u>mar</u> Day <u>27</u> Year <u>1959</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1940		9. AGE (in years last birthday) <u>18</u> yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unm / N.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Everett S. Lank</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Hewitt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Everett S. Lank (father)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>AS, hvxi: due to Aspiration of stomach contents</u> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>epileptic seizure</u> DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of epileptic seizure in past</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-27-59</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>		22e. (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>			
ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03305

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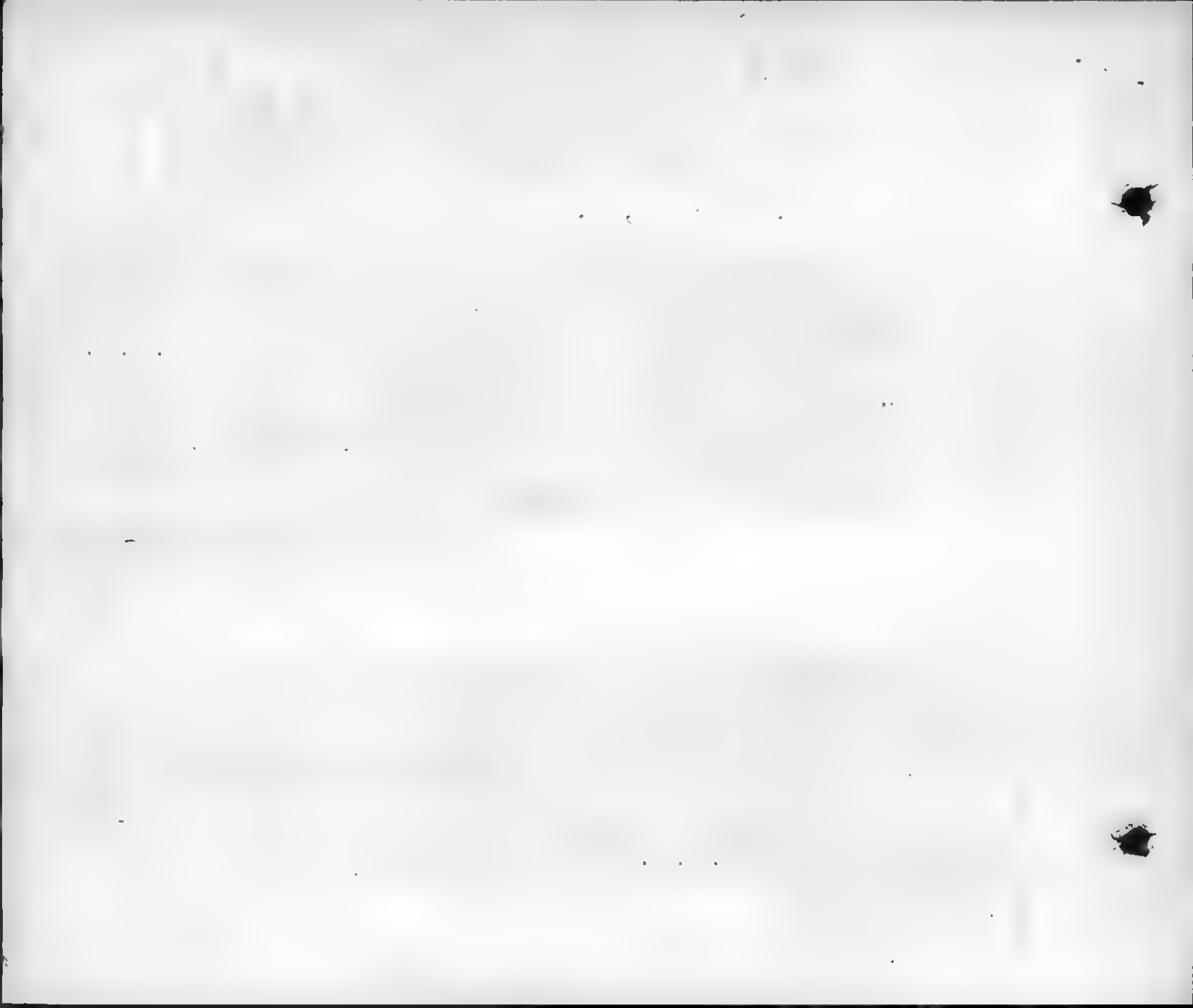
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Michigan b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 111 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 918 North Superior	
3. NAME OF DECEASED (Type or print) First Barbara Middle Louise Last Lent		4. DATE OF DEATH Month March Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1956
9. AGE (In years last birthday) yrs 2		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Child)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clifford H. Lent		14. MOTHER'S MAIDEN NAME Alma Noble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Subdural Hematoma, cerebral edema DUE TO (c) cerebellar ataxia			INTERVAL BETWEEN ONSET AND DEATH minutes 1-4 days 21 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 17, 19 58 to March 8, 19 59 that I last saw the deceased alive on March 8, 1959 , and that death occurred at 8:17 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bushnell Smith, M.D.</i>		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Bushnell Smith, M. D.		DATE SIGNED 3-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit	22b. DATE THEREOF 3/10/59	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Albion, Michigan
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR MAR 11 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3334

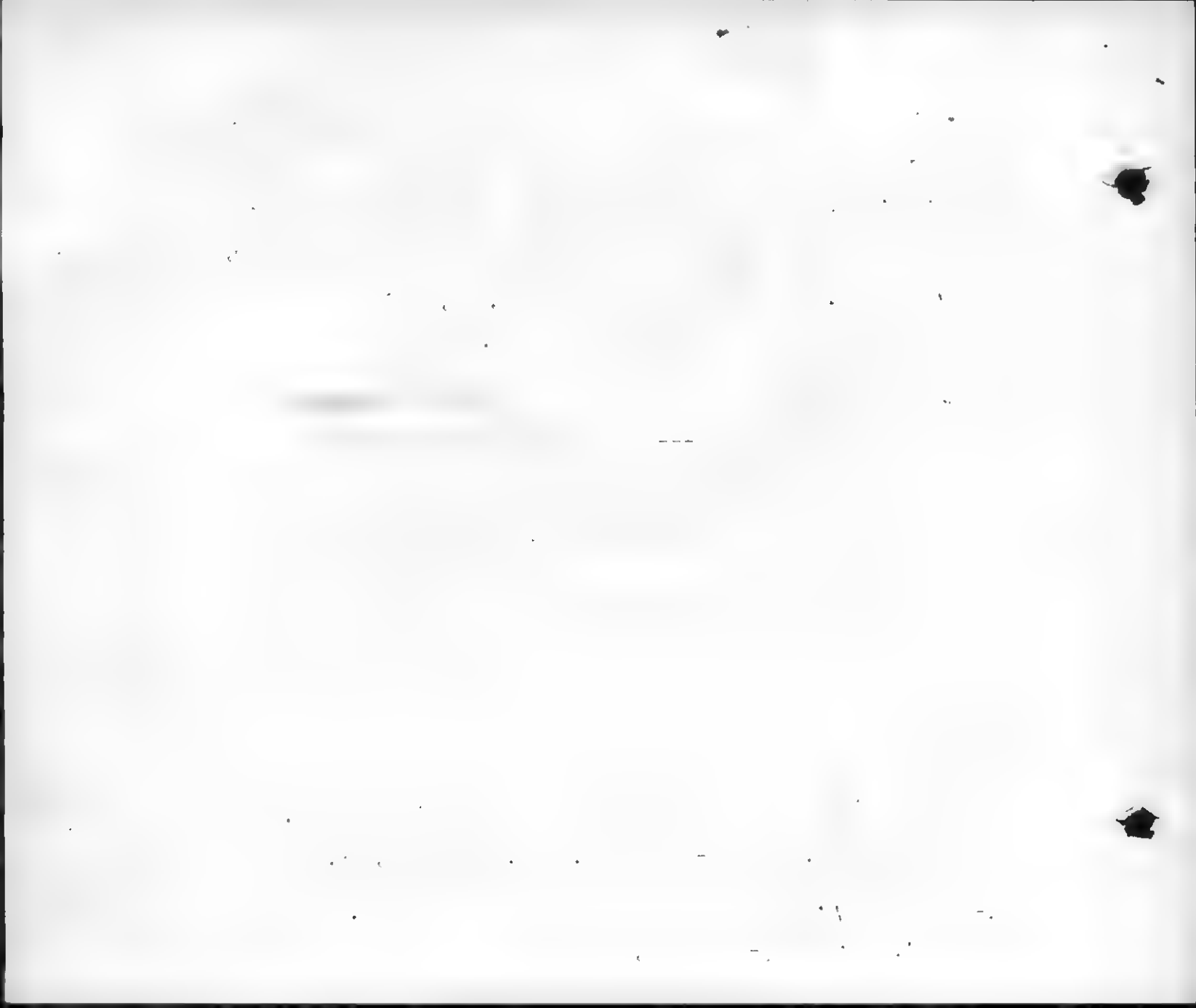
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4530 Avondale Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY JANE LIBBY				4. DATE OF DEATH Month March , Day 8 , Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1875	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months 0 Days 21	IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Daniel Arsenault				14. MOTHER'S MAIDEN NAME Mary Jane McHought			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -----		INFORMANT Mellon Libby-Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis General (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 23, 1959 to MAR. 8, 1959 that I last saw the deceased alive on MAR. 6, 1959 and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave., Bethesda, Md. DATE SIGNED 3/8/59							
ACTUAL SIGNATURE Leo M. Curtis		PHYSICIAN'S NAME (Type) Leo M. Curtis - 8218 Wis. Ave., Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Transit		22b. DATE THEREOF 3/8/59		22c. NAME OF CEMETERY OR CREMATORY Gray		22d. LOCATION (City, town, or county) (State) Gray, Maine	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR MAR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03307

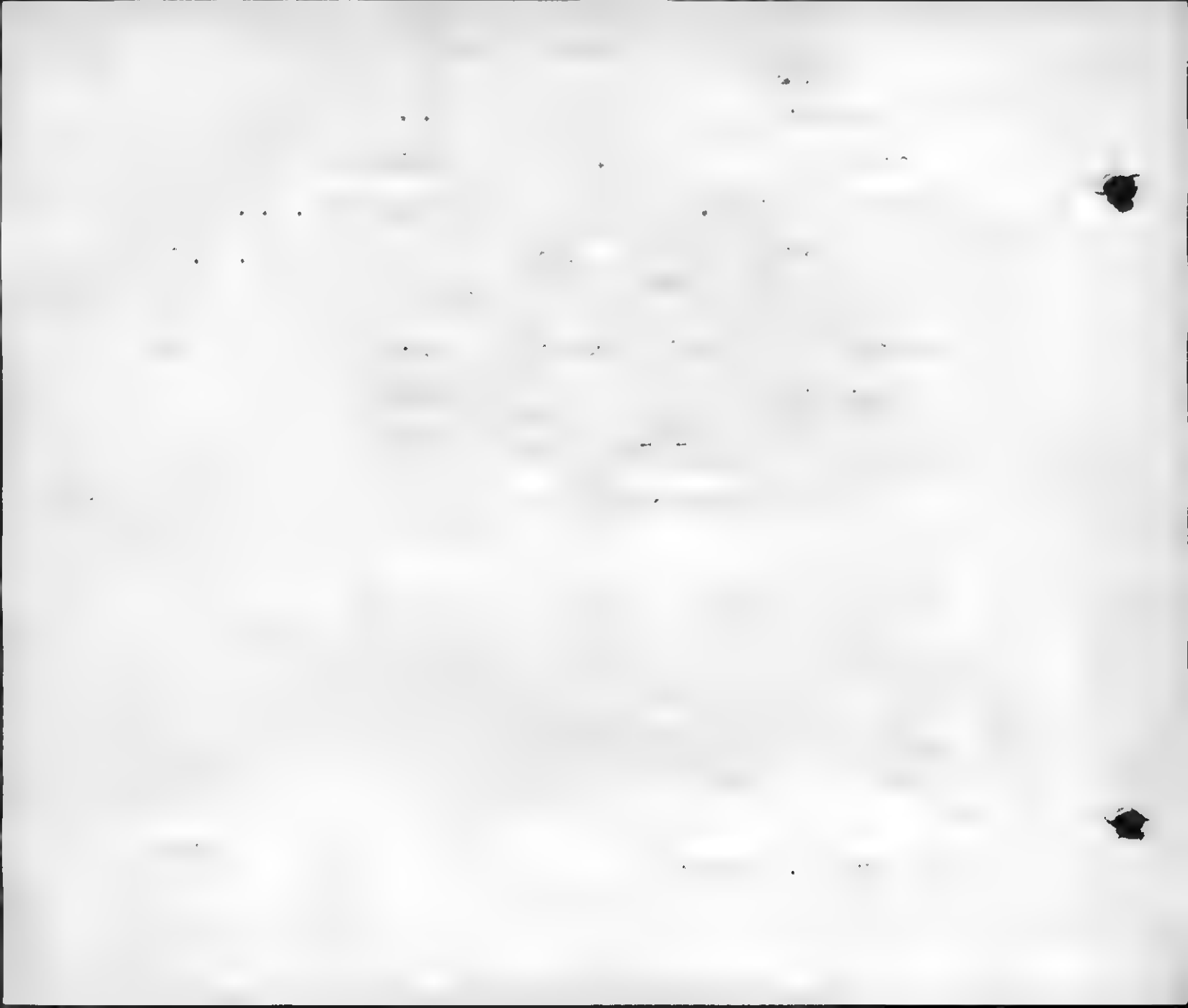
3335

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glen c. LENGTH OF STAY IN 1b 6hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Glen Annex Dispen.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5030 Eastern Ave. N.E. e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irving Liss		4. DATE OF DEATH Mar. 20. 1959 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/04
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10b. KIND OF BUSINESS OR INDUSTRY Building project	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARM David Liss		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 090-16-4217	
17. INFORMANT Rose Liss (wife)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Frank J. Broschart		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/20/59	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		22d. LOCATION (City, town, or county) (State) Falls Church Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danyauskyr Sons		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03308

3336

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6660 Hillandale Road</u>			d. STREET ADDRESS <u>6660 Hillandale Rd.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>LYNNE B LUNDBERG</u>			4. DATE OF DEATH Month Day Year <u>March 28 19 59</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>April 2, 1894</u>		9. AGE (In years, last birthday) <u>64</u> yrs		10. IF UNDER 24 HRS Months Days Hours Min. <u>11 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Utah</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frederick Lundberg</u>			
14. MOTHER'S MAIDEN NAME <u>Martha Berglin</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW 1</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Else Lundberg-wife-same as d2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO Cause lost (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>3/28/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>3/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ogden</u>	
22d. LOCATION (City, town, or county) <u>Ogden, Utah</u>		(State) <u>Utah</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REG. STRAR DATE <u>MAR 31 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>					

1. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03309

Reg. Dist. No.

3337

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown (rural)		c. LENGTH OF STAY IN life life		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Montg.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) James Theodore Lyles						4. DATE OF DEATH March 1, 1959			
5. SEX male		6. COLOR OR RACE ool.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1956		9. AGE (In years last birthday) 3 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harold Lyles						14. MOTHER'S MAIDEN NAME Helen Weadon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Helen Lyles (mother)		Address Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brocho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET OF DISEASE 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/59		22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel,		22d. LOCATION (City, town, or county) Hyattstown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Thomas		ADDRESS Rookville, Md.		24a. REC'D BY REGISTRAR DATE MAR 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

03310

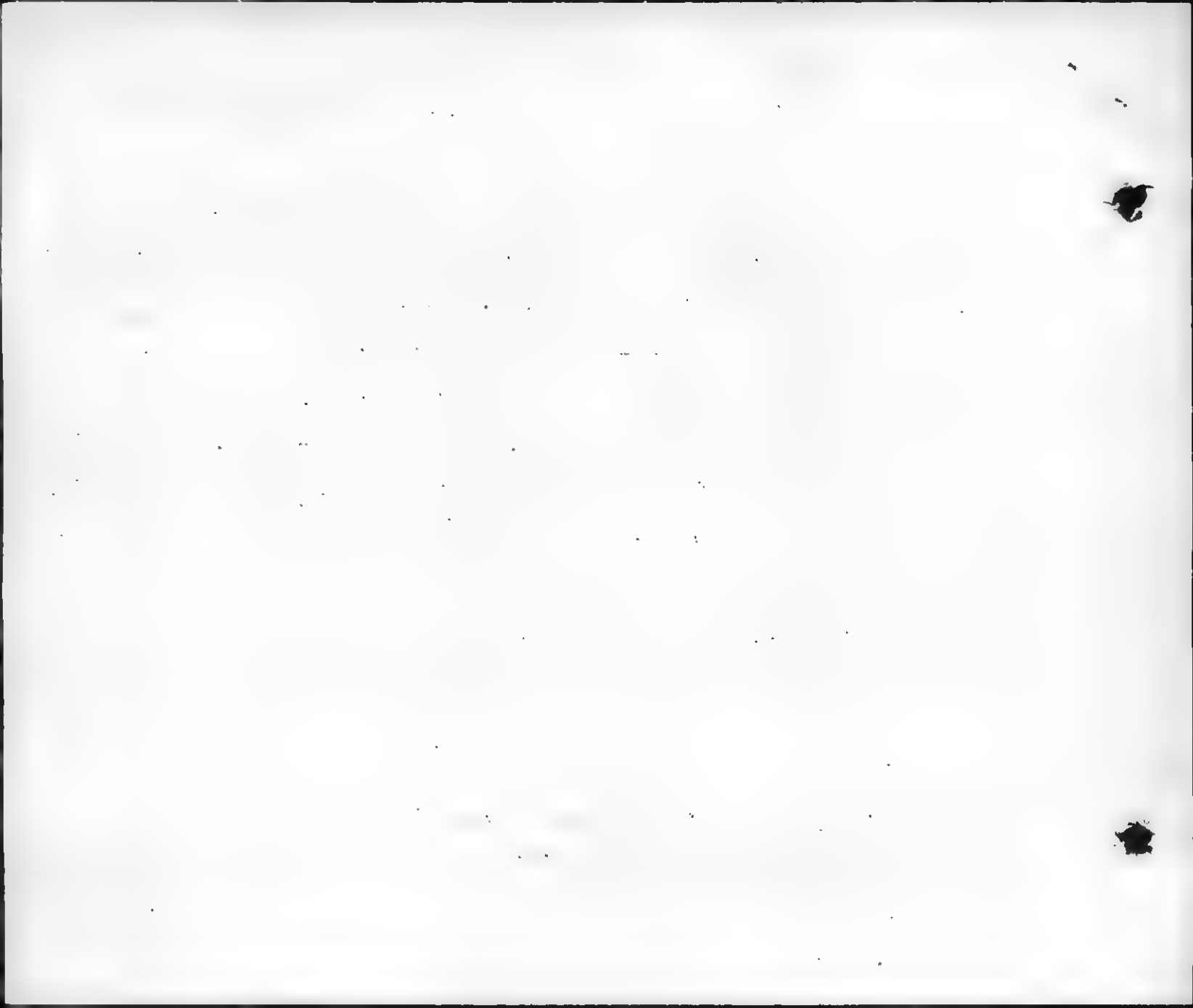
3338

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b X Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4419 Bradley Lane		/d. STREET ADDRESS 4419 Bradley Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle MAY Last MACAULAY		4. DATE OF DEATH Month March Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min 83	11. IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Benjamin Smith		14. MOTHER'S MAIDEN NAME Mary Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Dahl-daugh.		Address same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO (b) Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Many yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cardiac Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1957 to Mar 6, 1959 that I last saw the deceased alive on Mar 6, 1959 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bradley D. Hodgkins M.D.		ADDRESS (Street, city or town, state) 4413 Bradley Lane	
PHYSICIAN'S NAME (Type) BRADLEY D. HODGKINS		DATE SIGNED 3/6/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3/8/59	
22c. NAME OF CEMETERY OR CREMATORY Floydsburg Cemetery		22d. LOCATION (City, town, or county) (State) Crestwood, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

1

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3233

CERTIFICATE OF DEATH

03311

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
f. STREET ADDRESS <u>27 Primrose Street</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Winifred Reesa MacLay</u>				4. DATE OF DEATH <u>March 26 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-73</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11 BIRTHPLACE (State or foreign country) <u>Michigan</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Craine</u>				14. MOTHER'S MAIDEN NAME <u>Lucinda Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Mr. Malcolm MacLay - 7105 Peachum Pl., Bethesda</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>perforated ulcer</u>							
DUE TO <u>331X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>perforated ulcer with location</u>							
DUE TO <u>old age</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Long history of ulcer</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>fall from stairs</u>			
20c. TIME OF INJURY Month, Day, Year <u>3 1 1959</u>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>			
20e. (City or town) <u>Cherry Chase</u>				20f. (County) <u>Montgomery</u> (State) <u>Ind.</u>			
21. I certify that I attended the deceased from <u>2/1</u> 19 <u>59</u> , to <u>2/26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2/26</u> 19 <u>59</u> , and that death occurred at <u>2:15</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Washington Sanatorium</u> DATE SIGNED <u>3-27-59</u>							
ACTUAL SIGNATURE <u>Philip Bloemsa</u> M.D.							
PHYSICIAN'S NAME (Type) <u>PHILIP BLOEMSA</u> <u>Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>3-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>RAH 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03312

3234 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>D.C.</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>21 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		4'	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedar Haven Rest Home</u>		STREET ADDRESS <u>1507</u>		(If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Joseph Marrinan</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 12, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 23 1886</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist Newspaper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James William Marrinan</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Reagan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>142-30</u>		17. INFORMANT & ADDRESS <u>8206 Fisher Ave J.W. Marrinan Takoma Park Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Gastro-intestinal hemorrhage, massive</u>						<u>Terminal</u>	
ANTECEDENT CAUSE(S) DUE TO <u>And</u>						<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Lobar pneumonia, rt. middle and lower lobes</u>						<u>2 yrs. +</u>	
DUE TO <u>Bronchiectasis, chronic</u>						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Alcoholism</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 23, 1959</u> to <u>Mar. 12, 1959</u> , that I last saw the deceased alive on <u>Mar. 11, 1959</u> , and that death occurred at <u>2:52 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wallace H. Mook</u>		M.D. <u>7701 Carroll Ave. Takoma Park, Md.</u>		DATE SIGNED <u>3/12/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Mar 14, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stalder</u>		ADDRESS <u>254 Calver St. N.E.</u>	
DATE <u>MAR 13 '59</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3339
CERTIFICATE OF DEATH

03313

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b STATE Maryland c COUNTY Prince Georges			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c LENGTH OF STAY IN 1b 34 days			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e STREET ADDRESS 5309 Annapolis Road			
3 NAME OF DECEASED (Type or print) First Murray Middle Linwood Last Marshall				4 DATE OF DEATH Month March Day 10 Year 19 59			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 5, 1896		9 AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maine		12 CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Herman Marshall				14 MOTHER'S MAIDEN NAME Della McFarland			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16 SOCIAL SECURITY NO None		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Fibrosarcoma of left maxillary antrum with metastases to lung and brain (c) None						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a m. p. m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town)		(County) (State)	
21. I certify that I attended the deceased from February 4 , 19 59 , to March 10 , 19 59 , that I last saw the deceased alive on March 10 , 19 59 , and that death occurred at 7:05 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/10/59 ACTUAL SIGNATURE Howard M. Radwin, M.D. PHYSICIAN'S NAME (Type) Howard M. Radwin, M. D. The National Institutes of Health Bethesda 14, Maryland							
22a BURIAL, CREMATION, REINTERMENT (Specify)		22b DATE THEREOF 3/13/59		22c NAME OF CEMETERY OR CREMATORY Arlington National		22d LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a REC'D BY REGISTRAR MAR 16 '59		24b REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03314

3235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Saint Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Standish</u> Middle <u>Maykrantz</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/89</u>
9. AGE (In years last birthday) <u>69 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Vet. Adm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George N. Maykrantz</u>		14. MOTHER'S MAIDEN NAME <u>Rose Eline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>patient's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM, MASSIVE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY INFARCT, LEFT LOWER LOBE</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>2 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 22</u> , 19 <u>59</u> , to <u>Mar. 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 22</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. Humphreys, Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1246 K St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>C. W. Humphreys, Jr.</u>			
22a. BURIAL, CREMATION, REMAINS (Type) <u>cremation</u>		22b. DATE THEREOF <u>3/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>MAR 5 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Calvin S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3340

CERTIFICATE OF DEATH

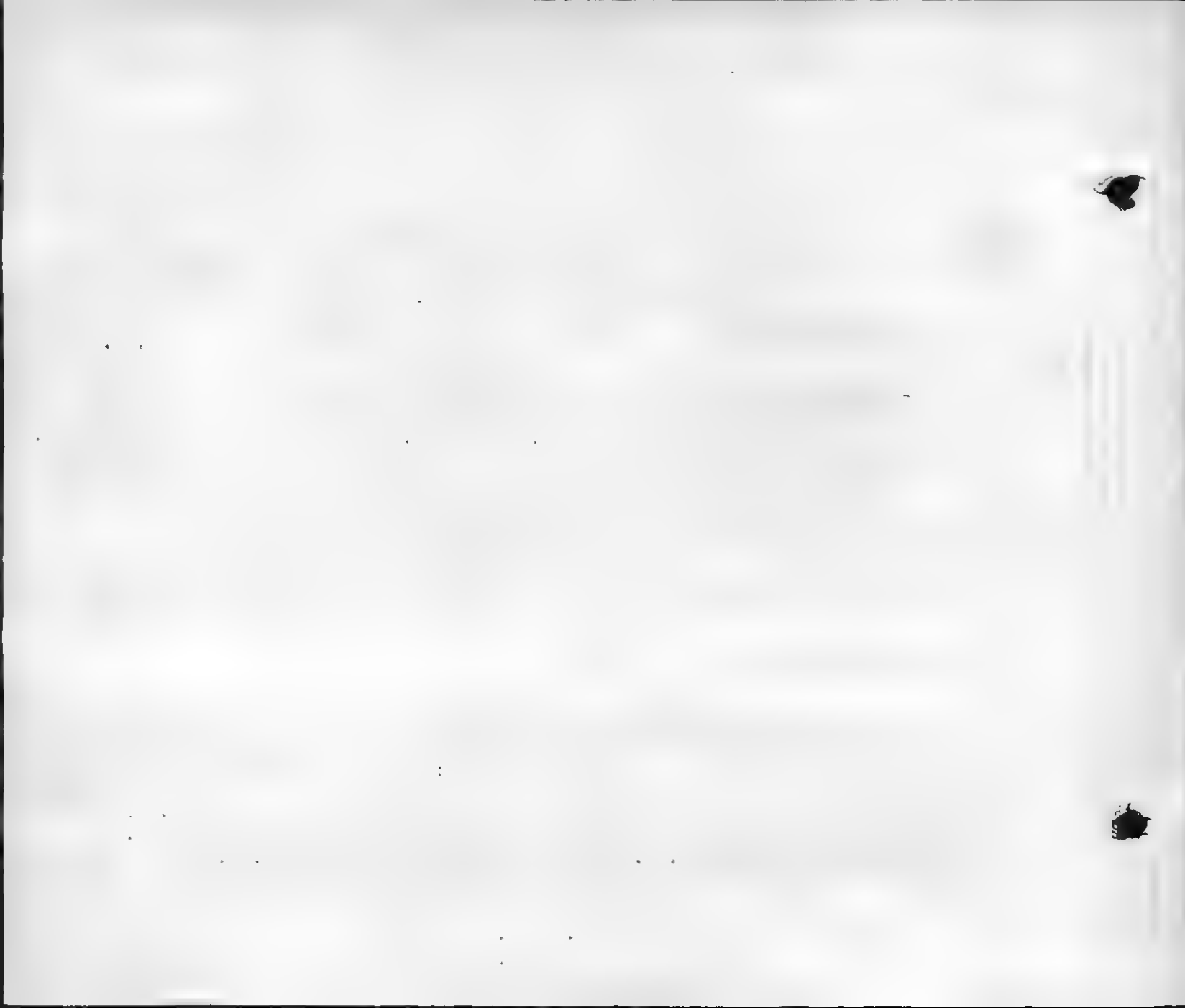
Reg. Dist. No.

03315

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Victoria</u> Last <u>Mc Alder</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Worn Kessel Wornkessel</u>		14. MOTHER'S MAIDEN NAME <u>Von Garlem</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ann Alden, 10505 Meredith Ave., Kens, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Fibrotic Bronchitis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Chronic</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>Summer</u> , 19 <u>28</u> , to <u>March 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 25</u> , 19 <u>59</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank L. Willman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2731 Connecticut Avenue, N. W. 3-26-59</u> <u>Washington, D. C.</u>	
PHYSICIAN'S NAME (Type) <u>Frank L. Willman, M. D.</u>		<u>2731 Connecticut Ave., N. W., Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery Washington, D.C.</u>	22d. LOCATION (City, town, or county) (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Orthus L. Hines</u>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

03311

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 470-1 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hopine Nursing Home 9807 River Road		d. STREET ADDRESS 2022 Pierce Mill Road, N.W.	
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last MCANENY		4. DATE OF DEATH Month MARCH Day 5 Year 1959	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June --1887
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR: Months 7 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Lemen		14. MOTHER'S MAIDEN NAME Nannie Hedges	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 8335 12th Avenue Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332 X DUE TO Cerebral disease probably thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Cerebral arteriosclerosis			
(c) 3 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Glaucoma. World diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1958 to May 5, 1959 that I last saw the deceased alive on May 4, 1959 and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Massie Page M.D.		ADDRESS (Street, city or town, state) 1150 Comm. Dr. Wash. D.C. DATE SIGNED May 5, 1959	
PHYSICIAN'S NAME (Type) R. MASSIE PAGE			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Jones - Central Washington, D.C.		24a. REC'D BY REGISTRAR MAR 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3342 CERTIFICATE OF DEATH

03317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery County General</i>		d. STREET ADDRESS <i>107 East Parmour Ave</i>	
3. NAME OF DECEASED (Type or print) <i>David</i> First Middle Last <i>M^r Bain</i>		4. DATE OF DEATH <i>March - 21 - 1959</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec - 25 - 1898</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>2</i> Days <i>24</i> Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manufacturing Sec</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sec</i>	
11. BIRTHPLACE (State or foreign country) <i>Gaithersburg, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i>	
13. FATHER'S NAME <i>William M^r Bain</i>		14. MOTHER'S MAIDEN NAME <i>Christine Bissett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>217-32-1708</i>	
17. INFORMANT <i>Wm K. Sawyer, 104 E. Quindar Ave, Gaithersburg, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>undetermined</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cirrhosis liver, cardiac asthma, aortic</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>10-15 minutes</i> <i>4-5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <i>59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March - 16 - 1959</i> , to <i>March - 21 - 1959</i> , that I last saw the deceased alive on <i>March - 21 - 1959</i> , and that death occurred at <i>7:35 P.</i> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7 - Brooks Ave</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		<i>Gaithersburg, Md</i>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-25-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>		22d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gartner, Gaithersburg, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR <i>DATE MAR 24 59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3343

CERTIFICATE OF DEATH

03318

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 102 E. Argyle St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Grace Anna MC CARTHY				4. DATE OF DEATH Month Day Year March 13 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-22-33	
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - -			
13. FATHER'S NAME Henry FOSTER				14. MOTHER'S MAIDEN NAME Effie ATTWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, give war or dates of service		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address (H) Gerald A. McCarthy, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS, Chronic recurrent Pyelonephritis DUE TO (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 6 mo 7 yrs 21 yrs						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 24, 1959 to March 13, 1959 , that I last saw the deceased alive on March 13, 1959 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMHC 3-13-59							
ACTUAL SIGNATURE John Wood Davis				M.D. U. S. Naval Hospital, NMHC			
PHYSICIAN'S NAME (Type) J. W. DAVIS, LT, MC, USN				Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi ADDRESS Rinaldi Funeral Home, 816 H St., NE, Wash., DC				24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03319

3254

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wooded area off Burbank Rd.		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission, a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase d. STREET ADDRESS 4112 Aspen St.	
3. NAME OF DECEASED (Type or print) Earl Edward McChesney		4. DATE OF DEATH Mar 20 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1921
9. AGE (In years last birthday) 37 yrs		10. IF UNDER 1 YEAR: Months 4 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Vital Statistics	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray McChesney		14. MOTHER'S MAIDEN NAME Edna Beck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 466-03-0965	
17. INFORMANT Wife		Address Same as Item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Found dead in auto with hose attached from exhaust	
20c. TIME OF INJURY Month, Day, Year 3/20/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) wooded area	20f. (City or town) Rockville Montg. Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 3/20/59	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-23-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) Arlington, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03320

Reg. Dist. No.

3236

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>1403 Merrimac Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Malcolm</u> First <u>McCrone</u> Middle <u>McCrone</u> Last				4. DATE OF DEATH <u>March 7</u> 19 <u>59</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct-3-1889</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gunner</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William McCrone</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cudney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>579-20-7195</u>		17. INFORMANT <u>PT's effort</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>1600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF LUNG</u> DUE TO (c) <u>GENERALIZED METASTASES</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u> <u>5405</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>SEPT 3, 1958</u> to <u>MARCH 17, 1959</u> , that I last saw the deceased alive on <u>MARCH 17, 1959</u> and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u>				ADDRESS (Street, city or town, state) <u>352 UNIVERSITY LA</u> <u>HYATTSVILLE MD</u>			
PHYSICIAN'S NAME (Type) <u>Harold Sterling</u>				DATE SIGNED <u>3/17/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Pumprey</u>				ADDRESS <u>Silver Spring, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	
24a. REC'D BY REGISTRAR <u>Walter E. Pumprey</u>				DATE <u>MAR 10 59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3237

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hosp.</u>				d. STREET ADDRESS <u>4101 Southeast Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>THOMAS</u> Last <u>McDonald</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12 - 1959</u> Infant <input type="checkbox"/> Yrs.		9. AGE (In years last birthday) <u>19</u>		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IN FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Edward McDonald</u>				14. MOTHER'S MAIDEN NAME <u>Joyce Ann Hagan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Circulatory Failure</u> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intracranial Edema</u> DUE TO (c) <u>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>59</u> , to <u>3/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Francis Scales</u> M.D.				ADDRESS (Street, city or town, state) <u>3547 Chesapeake NW Wash. DC</u>			
PHYSICIAN'S NAME (Type) <u>C. Francis Scales</u>				DATE SIGNED <u>3/19/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Formal</u>		22b. DATE THEREOF <u>MAR. 23 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. TAVILL</u> ADDRESS <u>3603 14th St NW DC</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18

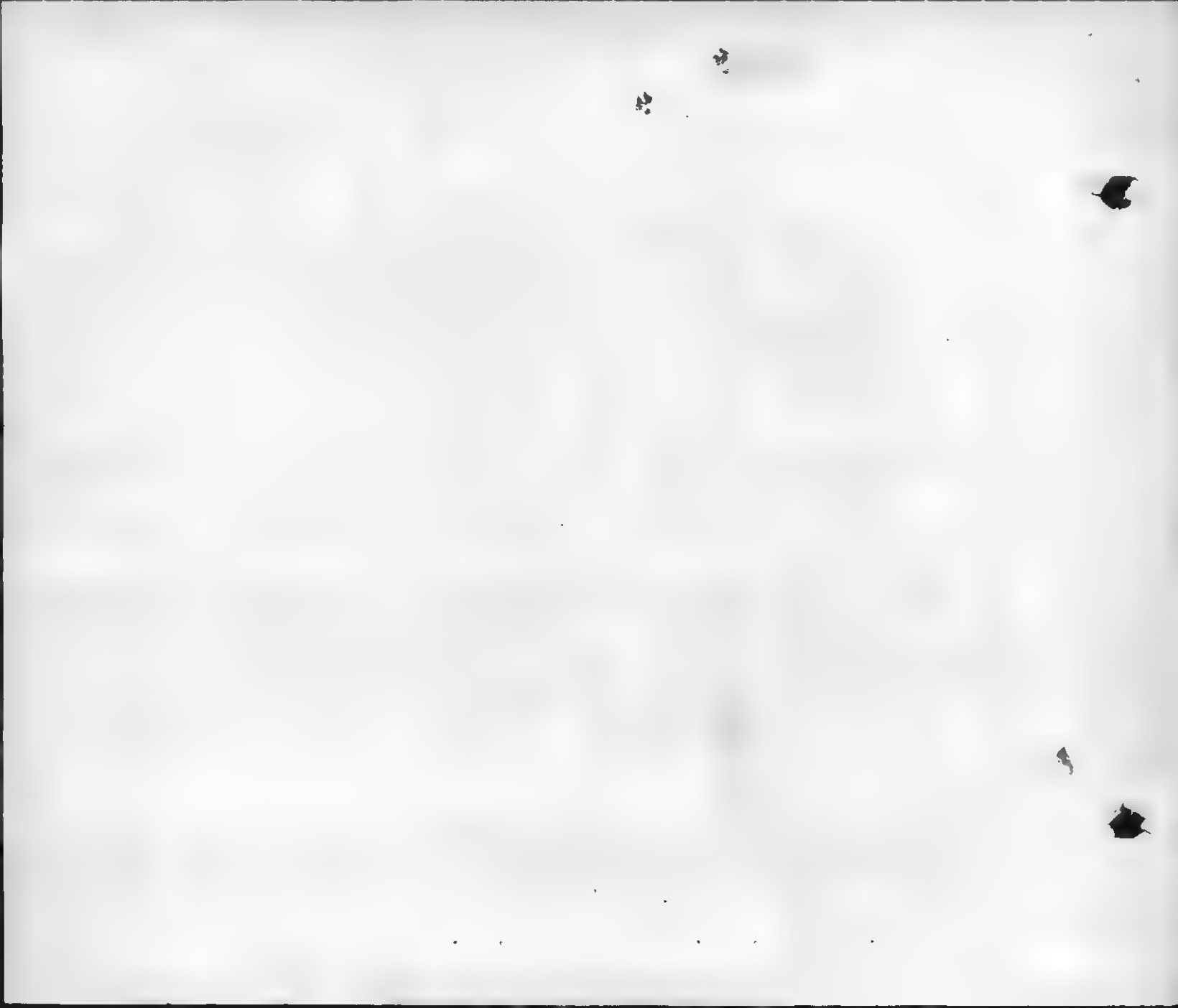
CERTIFICATE OF DEATH

Items 3 & 16, Film 3-1, 4/1/59

03322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium & Hosp.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1735 Dublin Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH GRACE MCGINN First Middle Last Grace Elizabeth McGinn				4. DATE OF DEATH Month March Day 13 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-16	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Williamson				14. MOTHER'S MAIDEN NAME Edith Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-10-6857		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 276x Congestive heart failure with pulmonary edema DUE TO (b) Intermittent left ventricular failure DUE TO (c) Left ventricular failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 hr. 2 hr. 2 wk.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13 19 59 , to 5-13 19 59 , that I last saw the deceased alive on 5-13 19 59 , and that death occurred at 11:20 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1735 Dublin Dr., Silver Spring, Md. DATE SIGNED 3-1-59							
ACTUAL SIGNATURE Arthur Williamson M. D.				DATE SIGNED 3-1-59			
PHYSICIAN'S NAME (Type) Arthur Williamson				DATE SIGNED 3-1-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/17/59		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03323

3344

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7927 Georgia Ave</u>			d. STREET ADDRESS <u>7927 Georgia Ave</u>		
3. NAME OF DECEASED (Type or print) <u>Thomas Rurdon McHale Jr</u>			4. DATE OF DEATH Month <u>mar</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-05</u>		9. AGE (In years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>clothing</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas McHale</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Etta Maloney</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>135-01-4990</u>		17. INFORMANT <u>Police Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4d0.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>19</u>	
		20f. (City or town) <u>19</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-15-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>		DATE <u>MAR 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thoma</u>	



3345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 89 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 9003 Glenville Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna May McIntyre		4. DATE OF DEATH Month March Day 28 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1892
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Fazenbaker		14. MOTHER'S MAIDEN NAME Janet Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO (b) Carcinoma of the Bladder DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 29, 19 58 to March 28, 19 59 , that I last saw the deceased alive on March 28, 19 59 , and that death occurred at 5:45 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 3-28-59			
ACTUAL SIGNATURE Jack Levin		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Jack Levin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/1959	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneave	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03325

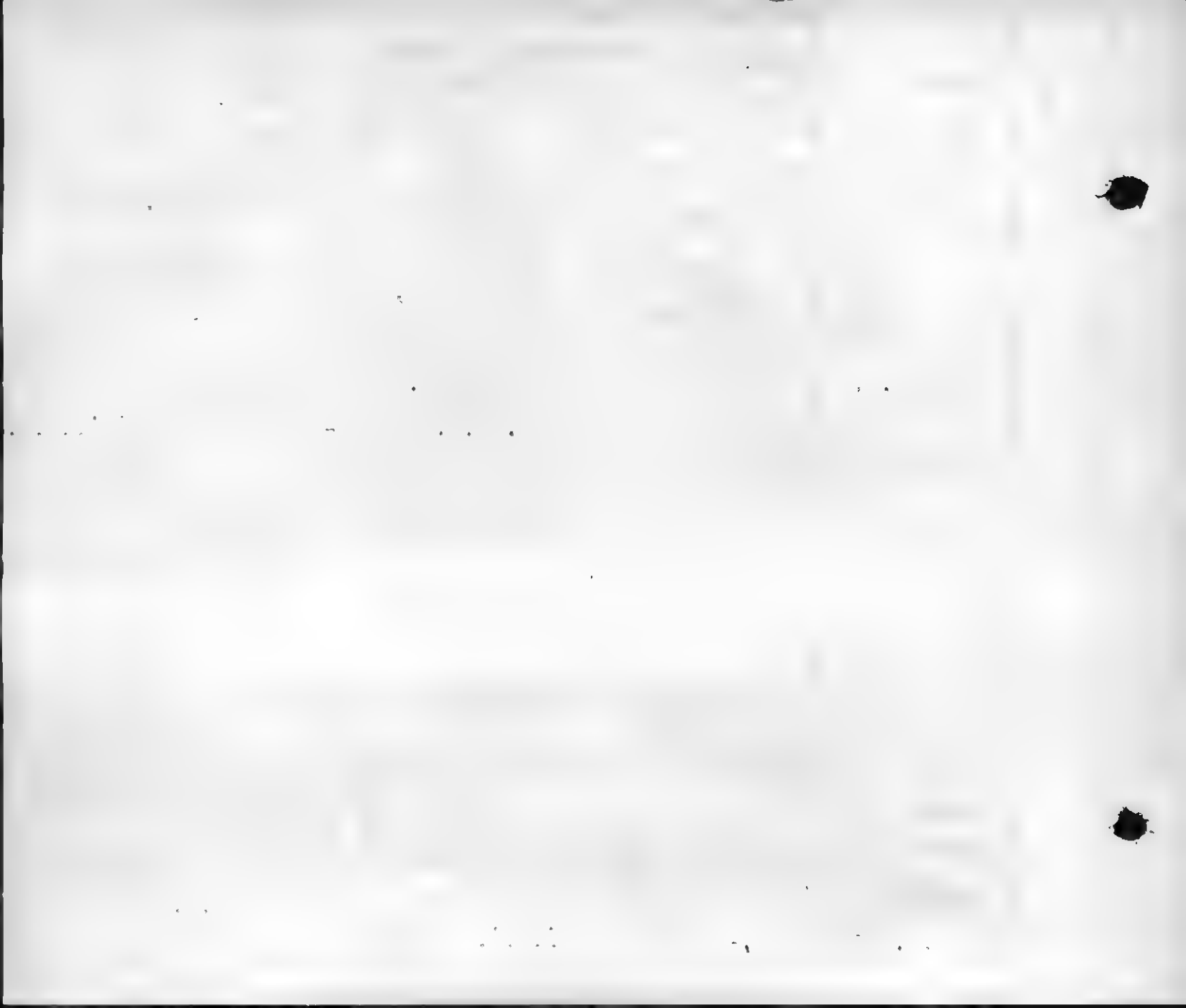
Reg. Dist. No.

3346

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>DC</u> b. COUNTY <u>--</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Carroll Hall Sanatorium</u>		d. STREET ADDRESS <u>4608 Fessenden Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth H. Miller</u>		4. DATE OF DEATH <u>Mar 4 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 16, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>91</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James K.P. Hoover</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. Coofelt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. E.W. Deerson</u>		Address <u>Wash. D.C. 4608 Fessenden St., N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour a. m. p. m. <u>None</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/15/36</u> 19 <u>36</u> to <u>3/4/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3/4/59</u> 19 <u>59</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhan</u>		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhan</u>		DATE SIGNED <u>3/4/59</u>	
22a. BURIAL OR CREMATION <u>XXXXXX</u>	22b. DATE THEREOF <u>3/7/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>3 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>5524 TRENT STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>Jacob</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/14/75</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Certified Public Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canton, Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herb L. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Marcia Lucinda Bostwick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>No</u>		17. INFORMANT Address <u>Marcia J. Miller (Daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>410 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Mitral insufficiency</u> DUE TO (c) <u>Healed rheumatic mitral valvulitis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 19 1959</u> to <u>Mar 26 1959</u> , that I last saw the deceased alive on <u>Mar 26 1959</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Michel M. Healy</u>				ADDRESS (Street, city or town, state) <u>Washington Clinic Wash DC</u> DATE SIGNED <u>3/27/59</u>			
PHYSICIAN'S NAME (Type) <u>Michel M. Healy, Washington Clinic, Washington 15, D. C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey - Bethesda 14, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



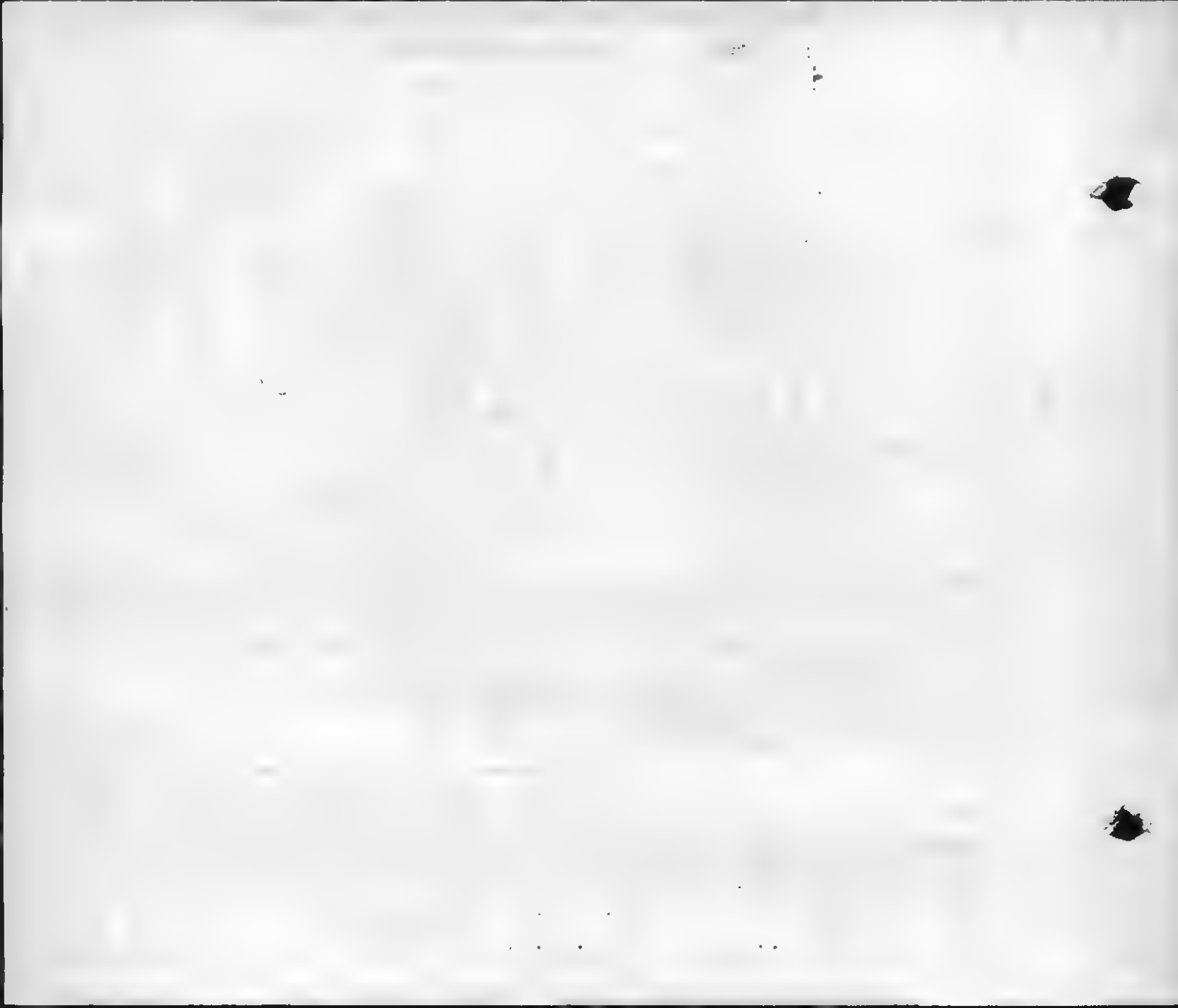
3348

CERTIFICATE OF DEATH

03327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) 10703 HAYES AVENUE		d. STREET ADDRESS 10703 HAYES AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last CORA ANNIE MITCHELL		4. DATE OF DEATH Month Day Year Mar 28 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS MATTOX		14. MOTHER'S MAIDEN NAME ANNIE H. OWEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. KALLAN DUNN (DAUGHTER)		Address 10703 HAYES AVE. SILVER SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary Infarction 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Disease DUE TO (c) Coronary Artery Disease & Infarction			INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1953 , to Mar 28, 1959 , that I last saw the deceased alive on Mar 27, 1959 , and that death occurred at 7:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Herbert Bauersfeld M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1912 R St N.W. DC 3/28/59	
PHYSICIAN'S NAME (Type) E. Herbert Bauersfeld Washington D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 3/28/59	22c. NAME OF CEMETERY OR CREMATORY BURLINGTON	22d. LOCATION (City, town or county) (State) BURLINGTON, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24. REGISTRAR'S SIGNATURE Arthur E. Hines	



3239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN TB <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyaltsville</u>			
d. STREET ADDRESS <u>1350 Langley Way</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Irene</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1959</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-74</u>	9. AGE (In years last b'day) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Adam Rupert</u>				14 MOTHER'S MAIDEN NAME <u>Sophia Ruddock</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16 SOCIAL SECURITY NO. <u>-</u>		17 INFORMANT <u>Hospital Records</u> Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9 x 10 Inter trochanteric Fracture, 19 femur 3/1/59</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell in living room of home</u>			
20c. TIME OF INJURY Hour <u>4-30</u> a.m. <u>p.m.</u> Month <u>3/1</u> Day <u>1</u> Year <u>1959</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Hyaltsville</u>		20g. (County) <u>Cum gratia</u>	
				20h. (State) <u>md</u>			
21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>59</u> , to <u>3/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>59</u> , and that death occurred at <u>4:45 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dean H. Harding</u>				ADDRESS (Street, city or town, state) <u>113 Carroll St NW-Wash 12 DC</u>			
PHYSICIAN'S NAME (Type) <u>Dean H. Harding, M. D.</u>				DATE SIGNED <u>3/28/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>March 31, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) <u>Prince George County, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Walter T. ...</u>				ADDRESS <u>250 Carroll St NW 11C</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	
						24b. REG STRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3/28/59

Mr Broadbent notified and
will appear. Jeanette H. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

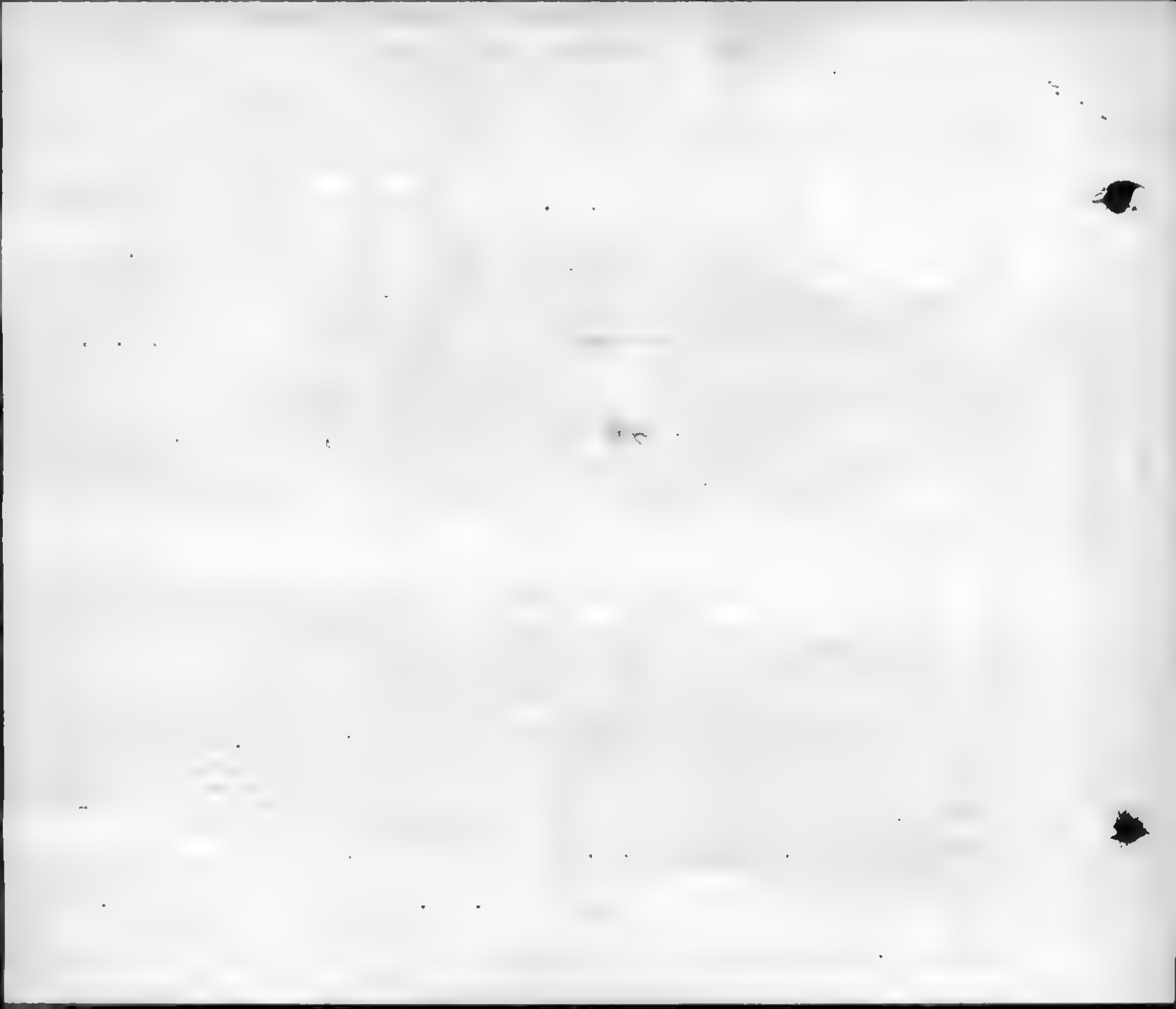
3349

CERTIFICATE OF DEATH

0332.1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 46 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 10304 Farnham Drive			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Thomas Middle Bryan Last Moore		4. DATE OF DEATH		Month March Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1927		9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Biochemist		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Watson Moore				14. MOTHER'S MAIDEN NAME Marjorie McAlpine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 243-329453		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hodgkins DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 11 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 15, 19 59 to March 2, 19 59 , that I last saw the deceased alive on March 2, 19 59 , and that death occurred at 6:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Arthur T. Teplitzky M.D. The Clinical Center 3-3-59 National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Bur-Transit		2/5/59		Hopewell Presby. Ch.		MacLenbury County, N. Car	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



3350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Md</u>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <u>Md</u> b. COUNTY <u>Montgomery Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>I</u>		d. STREET ADDRESS <u>602 Dartmouth Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellen L Morris</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months <u>6</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Isaac H Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Frank F Perkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>602 240 000</u>	
17. INFORMANT <u>Frank F Perkins</u>		Address <u>Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arterio sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December</u> , 19 <u>58</u> , to <u>March 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 25</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr. M.D.</u>		DATE SIGNED <u>March 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington M.C.M.</u>	22d. LOCATION (City, town, or county) (State) <u>C</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Henderson</u>		24a. REC'D BY REGISTRAR <u>W. J. Henderson</u>	
ADDRESS <u>3732 4th St N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Henderson</u>	
DATE <u>MAR 30 '59</u>			

V5 A15 (4)
15M 9/55



3351

CERTIFICATE OF DEATH

Reg. Dist. No.

03331

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>			
c. LENGTH OF STAY IN 1b <u>3 MOS.</u>				d. STREET ADDRESS <u>201 Nth WAYNE ST. (APT. #1)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6203 MAIDEN LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIAN ELIZABETH MURRAY</u>				4. DATE OF DEATH Month Day Year <u>March 25 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERICAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT. (RET.)</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SILAS HANCE MOORE</u>				14. MOTHER'S MAIDEN NAME <u>ANNE REBECCA COOK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>R.W. MURRAY (SON) 6203 MAIDEN LANE BETHESDA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of breast (right)</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1940</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan. 15, 1959</u> , to <u>March 25, 1959</u> , that I last saw the deceased alive on <u>March 25, 1959</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Katharine A. Chapman</u> M.D. <u>3924 Baltimore St.</u>				DATE SIGNED <u>March 25, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u>				<u>Kensington, Maryland</u>			
22a. BURIAL, CREMATION, 9560 (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3352

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 26hr.26min.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 2703 Upshur Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Laura Middle (none) Last NAYLOR		4. DATE OF DEATH Month March Day 20 Year 19 59			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-59		9. AGE (In years last birthday) yrs 1	IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY ---			11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Roger NAYLOR				14. MOTHER'S MAIDEN NAME Lourdes Alberta FIGUEROA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Roger Naylor, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal atelectasis 76 x .5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) since birth							INTERVAL BETWEEN ONSET AND DEATH since birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19 , 19 59 , to March 20 , 19 59 , that I last saw the deceased alive on March 19 , 19 59 , and that death occurred at 6:04A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David Harris				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 3-20-59	
PHYSICIAN'S NAME (Type) David HARRIS, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY				24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

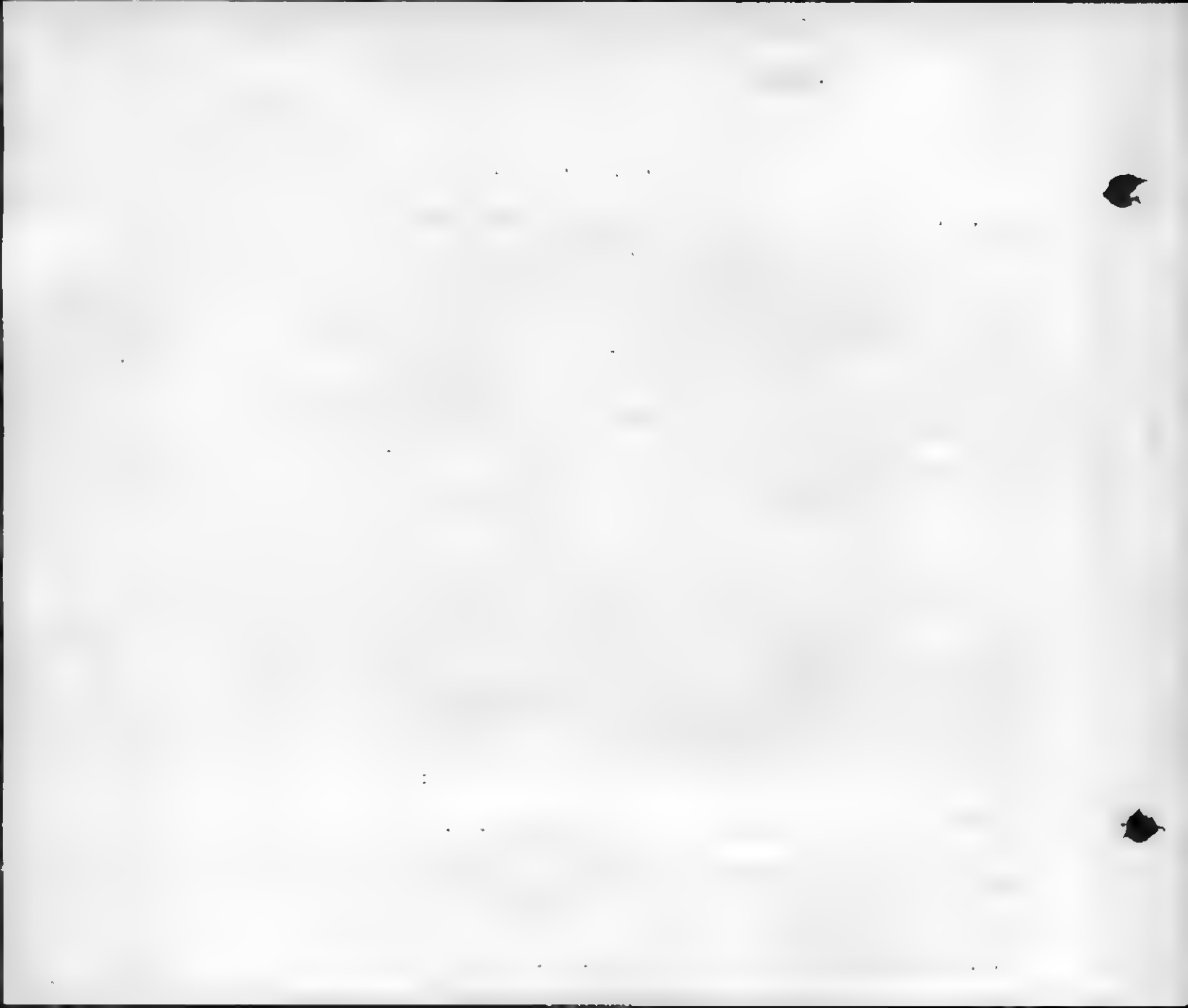


3353
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 6hr. 55min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier 1616.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 2703 Upshur Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Loretta (none) NAYLOR				4. DATE OF DEATH Month Day Year March 19 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-19-59	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Roger NAYLOR				14. MOTHER'S MAIDEN NAME Lourdes Alberta FIGUEROA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (F) Roger Naylor, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Neonatal atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 7 hr 7 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19 , 19 59 , to March 19 , 19 59 , that I last saw the deceased alive on March 19 , 19 59 , and that death occurred at 10:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED D. Harris M.D. U. S. Naval Hospital, NNMC 3-19-59 PHYSICIAN'S NAME (Type) David HARRIS, LT, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PULPHREY FUNERAL HOME, BETHESDA, MD.				24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03334

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>39 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8829 Brookville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clifford Nelson</u>		4. DATE OF DEATH <u>mar 30 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-1890</u>
9. AGE (in years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Walter Nelson</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>4214</u>	
17. INFORMANT <u>Florence Nelson (wife)</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Chronic valvular heart disease</u> DUE TO (c) <u>12 hrs - 1 year</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATORY, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Olarum Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md</u>	
24a. REC'D BY REGISTRAR <u>APR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



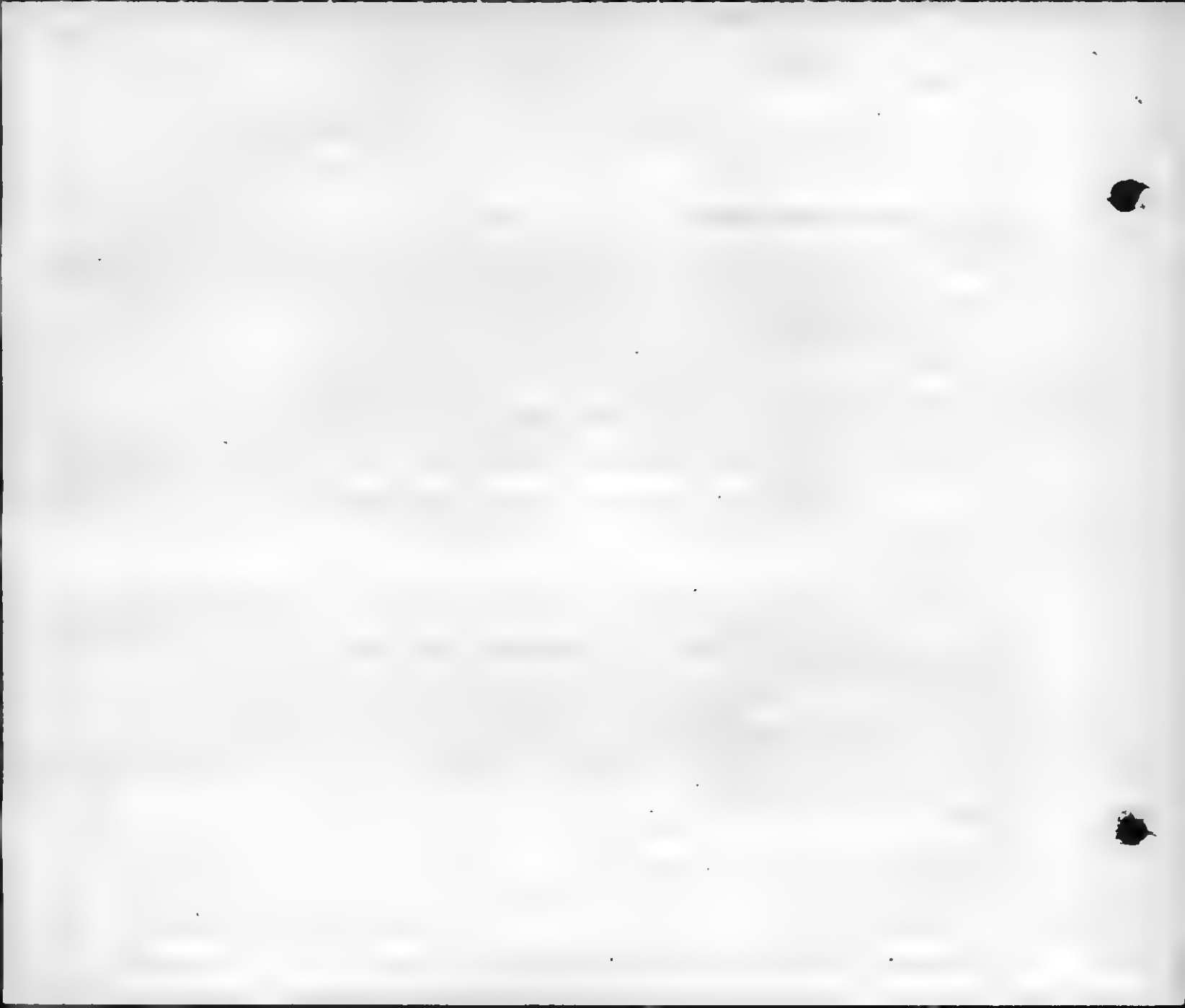
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3355 CERTIFICATE OF DEATH

Reg. Dist. No.

03335

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Virginia b. COUNTY Botetourt		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eagle Rock		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Rest Home			d. STREET ADDRESS None		
3. NAME OF DECEASED (Type or print) CELEA R. NOFFSINGER			4. DATE OF DEATH March 9 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1885		9. AGE (In years and birthday) 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Preston Wilhelm			14. MOTHER'S MAIDEN NAME Ada Sprinkle		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Theodore J Noffsinger-son-Gaithersburg, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 400x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebotomy with clot DUE TO (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Hemiplegia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour a. p. m. ----- 19 -----	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----	(County) ----- (State) -----
21. I certify that I attended the deceased from 11 Nov 1958 to 7 March 1959 , that I last saw the deceased alive on 7 March 1959 , and that death occurred at 4:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dawsonville P.O. Boyd DATE SIGNED 3/9/59					
ACTUAL SIGNATURE John G. Fawcett		M.D. Dawsonville P.O. Boyd			
PHYSICIAN'S NAME (Type) JOHN G. FAWCETT MD		Dawsonville P.O. Boyd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	22b. DATE THEREOF 3/12/59	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Roanoke, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 11 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kenna



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

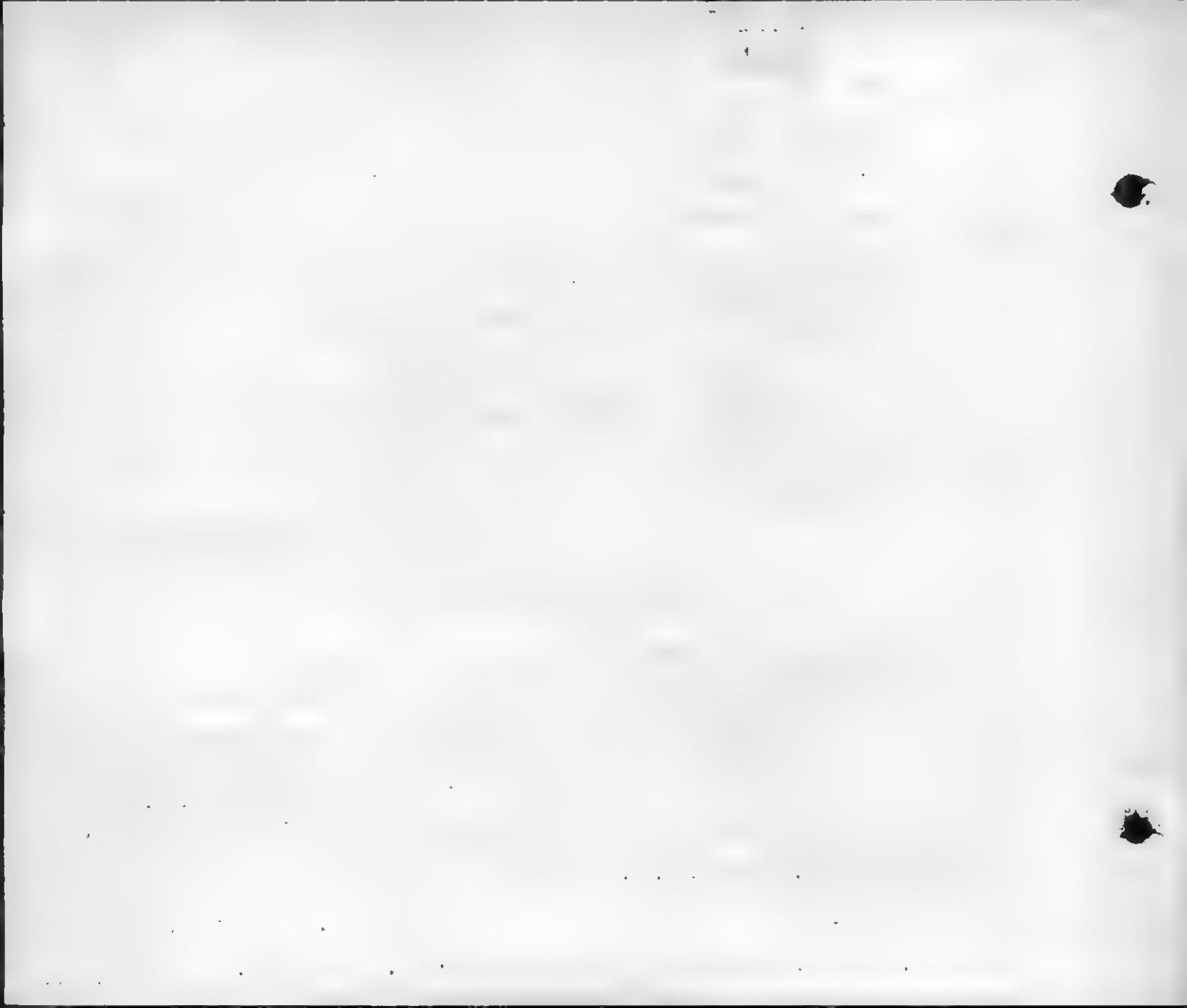
3240

CERTIFICATE OF DEATH

03336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		c. LENGTH OF STAY IN 1b Hyattsville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		d. STREET ADDRESS 6016 84th Avenue,	
3. NAME OF DECEASED (Type or print) First Middle Last Novotsky		4. DATE OF DEATH Month Day Year March 24, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. Months Days Hours Min 4 0
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Walter (NMN) Novotsky		14. MOTHER'S MAIDEN NAME Anne Grace Blackwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. father	
17. INFORMANT father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776X DUE TO Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-24 , 19 59 , to March 24, 1959 , that I last saw the deceased alive on 3-24 , 19 59 , and that death occurred at 9:20 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3-24-59 DATE SIGNED ACTUAL SIGNATURE Winston E. Cochran M.D. 927 Pershing Drive, Silver Spring, Md. PHYSICIAN'S NAME (Type) Winston E. Cochran, M. D. 927 Pershing Drive, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL. (Specify) Cremation		22b. DATE THEREOF 3-24-59	
22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hosp. Takoma Park, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hosp. Takoma Park, Maryland		24. REC'D BY REGISTRAR MAR 26 59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	



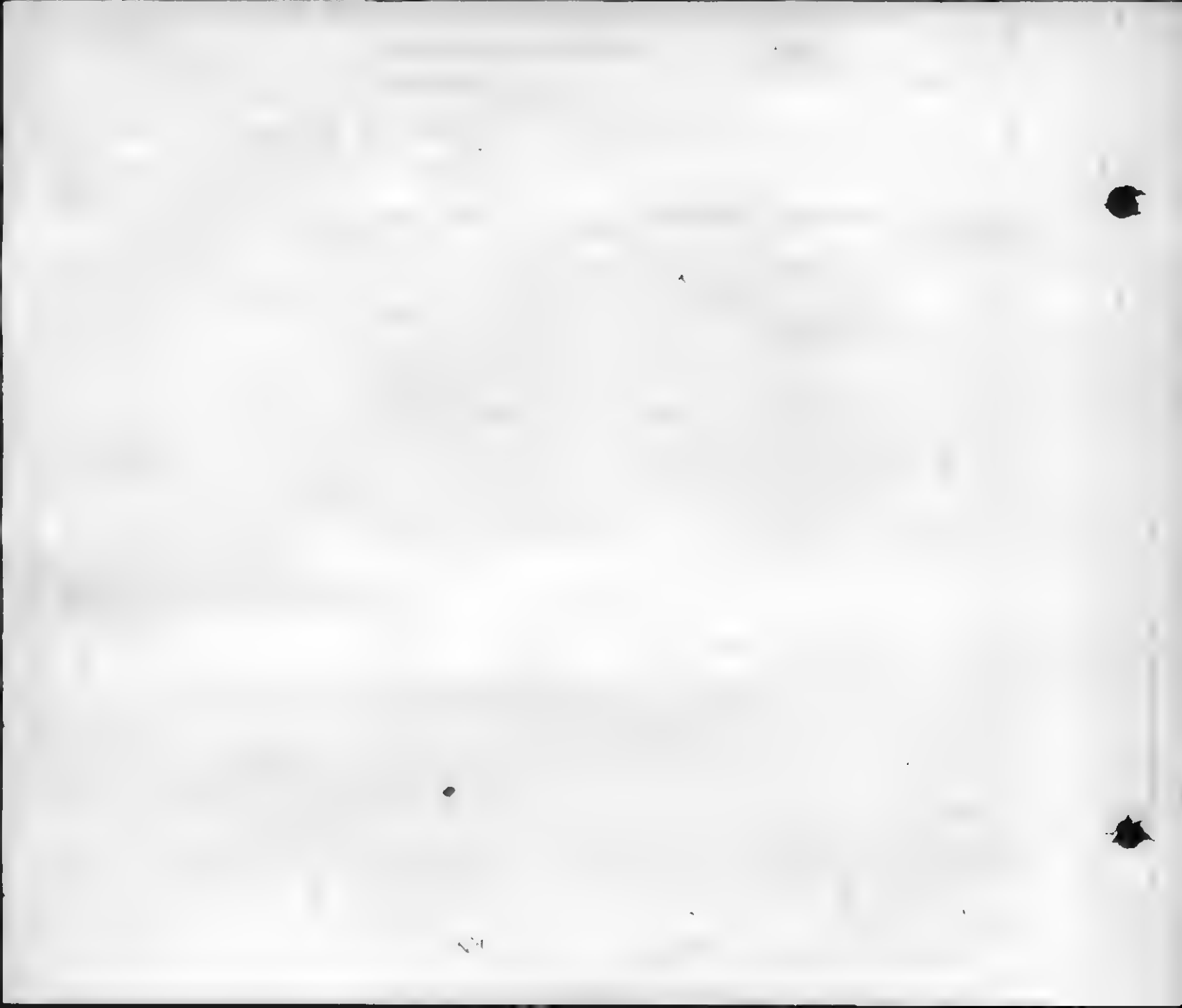
3356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>5600 Rockville Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Nabel C'Connor</u>				4. DATE OF DEATH Month <u>03</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 1920</u>	9. AGE (In years last birthday) <u>38</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
13. FATHER'S NAME <u>Willis H. Hoyt</u>				14. MOTHER'S MAIDEN NAME <u>Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Husband - William Connors</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured Cerebral Aneurysm</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>7 Hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11:30 AM 3/10/59</u> 19 <u>59</u> , to <u>6:00 PM 3/10, 1959</u> , that I last saw the deceased alive on <u>3-10-59</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul D. Cantor</u>				ADDRESS (Street, city or town, state) <u>4709 Montgomery Lane Bethesda 14 MD</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-13-59</u>		<u>GATE OF HEAVEN SILVER SPRINGS MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Eugene Home</u>				ADDRESS <u>3831 GA</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03338

Reg. Dist. No.

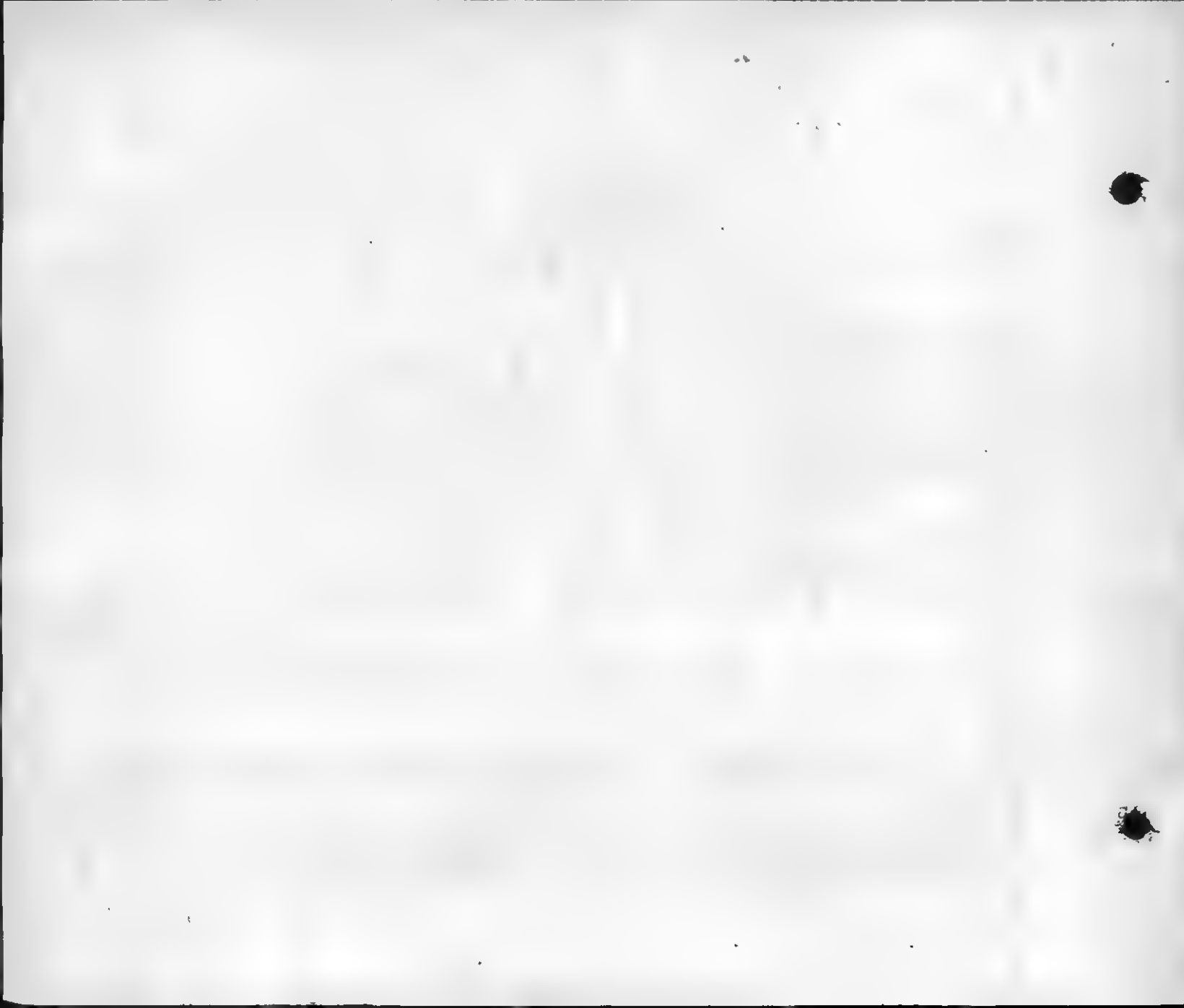
3357

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>55 yrs</u>		d. STREET ADDRESS <u>1001 Briggs-Cherry Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1001 Briggs-Cherry Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edna Elizabeth O'Keefe</u>	First Middle Last	4. DATE OF DEATH <u>Mar 30 1959</u>	Month Day Year
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Ind</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Andrew J. Harding</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Myers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Gertrude Barth (daughter)</u>		Address: <u>838 Rockville Pike Rockville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		DATE SIGNED <u>3-30-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond D. Ziska</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03331

3358

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 6 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47K	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS 922 M St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Emerson Overholt		4. DATE OF DEATH Month Day Year March 19 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1864
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Attorney		10b. KIND OF BUSINESS OR INDUSTRY Law	
11. BIRTHPLACE (State or foreign country) Buckeye Cove, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Overholt		14. MOTHER'S MAIDEN NAME Mary J. McNeill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown		16. SOCIAL SECURITY NO None	
17. INFORMANT Asbury Methodist Home, Records		Address Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular Accident 4. 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio Vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-23 , 19 57 , to 3-19 , 19 59 , that I last saw the deceased alive on 3-19 , 19 59 , and that death occurred at 9:50 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state), DATE SIGNED ACTUAL SIGNATURE Sarah E. Glover M.D. 10128 Cedar Lane Kensington Md, 3-19-59 PHYSICIAN'S NAME (Type) Sarah L. Glover			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar-23-59	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner.		ADDRESS Gaithersburg.	
24a. REC'D BY REGISTRAR DATE MAR 23 '59		24b. REGISTRAR'S SIGNATURE C. Long & House	

72-1402

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3359
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 1634 N. Buchanan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Arthur PARQUETTE		4. DATE OF DEATH Month Day Year March 16 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-88
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Victor PARQUETTE	
14. MOTHER'S MAIDEN NAME Clarissa GARIPEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1905 to 1940	
16. SOCIAL SECURITY NO 577-36-4762		17. INFORMANT (W) Mrs. Carol Lee Parquette, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse bilateral lobular pneumonia 491X DUE TO probably staphylococcal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 13 , 19 59 , to March 16 , 19 59 , that I last saw the deceased alive on March 15 , 19 59 , and that death occurred at 0630A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome A. Gold		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN		DATE SIGNED 3-16-59	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-19-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.		24a. REC'D BY REGISTRAR APR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 240 3-30-59 et

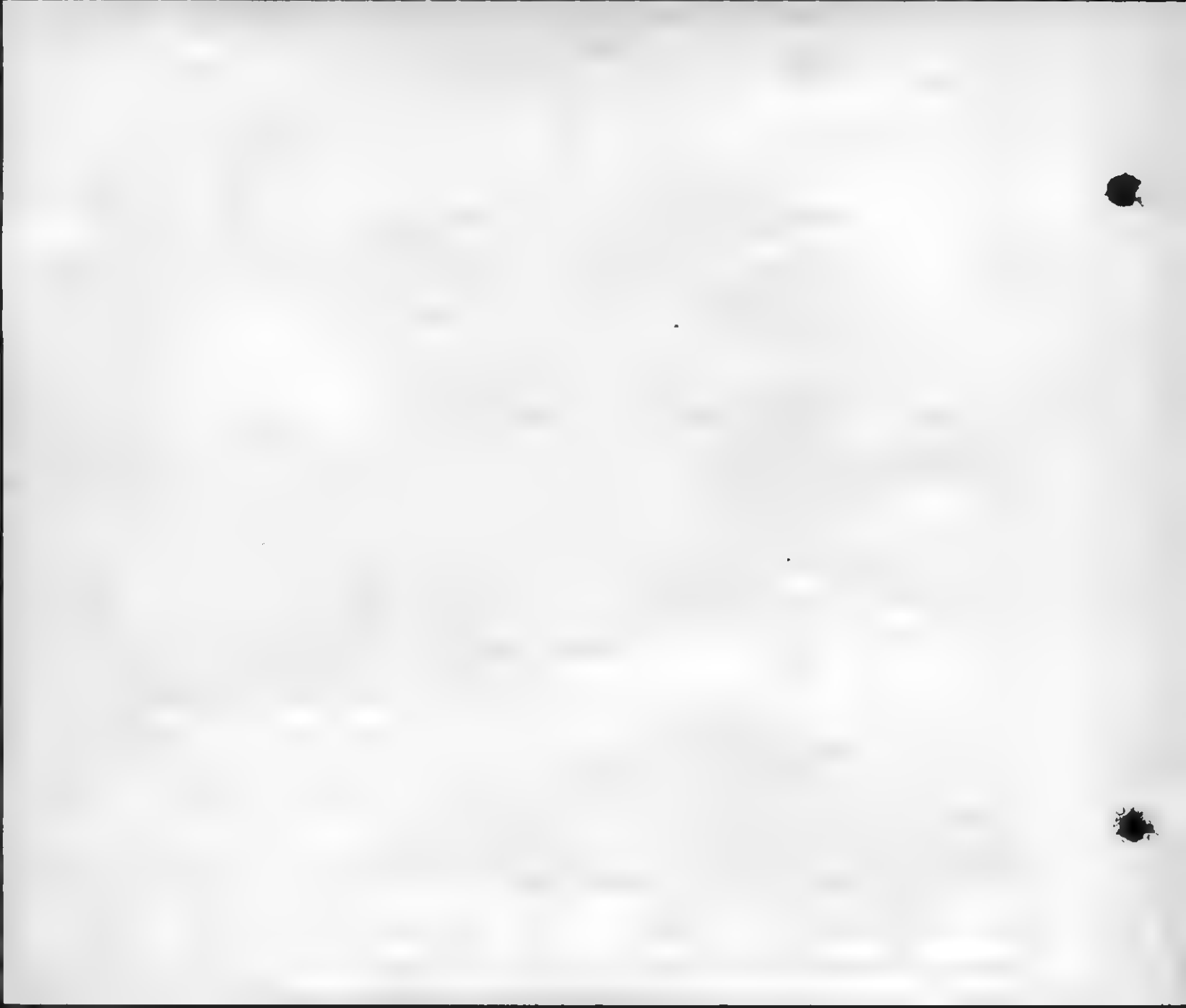
3360

CERTIFICATE OF DEATH

Reg. Dist. No.

03341

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Columbia Road</u>			1. d STREET ADDRESS <u>Columbia Rd</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>S.</u> Last <u>PARTRIDGE</u>			4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4, 1903</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GOVERNNESS</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>SANTE SANTINI</u>			14. MOTHER'S MAIDEN NAME <u>MARGHERITA MASCHIL</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)			16. SOCIAL SECURITY NO. <u>4 P Santini, Burtonsville, Md</u>		
17. INFORMANT <u>Address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia - (Renal failure)</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ovarian carcinoma with</u> DUE TO <u>suspected metastases</u> (c)					INTERVAL BETWEEN ONSET AND DEATH <u>8 mos - 24 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> <u>Cholecystitis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct</u> , 1958, to <u>March 21</u> , 1959, that I last saw the deceased alive on <u>March 21</u> , 1959, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John R. Spencer</u> M.D.			ADDRESS (Street, city or town, state) <u>Columbia Road</u> DATE SIGNED <u>Burtonsville, Md</u>		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 24, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel</u> <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St N C</u>			24a. REC'D BY REGISTRAR <u>DATE</u> <u>24 '59</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03242

3361

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 110 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mississippi b. COUNTY Lauderdale c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meridian d. STREET ADDRESS 1903 14th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Howell PEEBLES		4. DATE OF DEATH Month Day Year March 2 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-98
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac PEEBLES		14. MOTHER'S MAIDEN NAME Mamie A. RUSH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO 552-22-4669	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 12, 19 58 to March 2 , 19 59 , that I last saw the deceased alive on March 2 , 19 59 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 3-3-59			
ACTUAL SIGNATURE M. C. Shea		M.D. U. S. Naval Hospital, NMMC	
PHYSICIAN'S NAME (Type) M. C. SHEA, LT, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial, Shipment		22b. DATE THEREOF 3-3-59	
22c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery		22d. LOCATION (City, town, or county) (State) Meridian Mississippi	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS Funeral Home, Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2.57

18 Film 241
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03343

3362

Reg. Dist No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>3 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4221 Sleepord Rd</u>		d. STREET ADDRESS <u>4221 Sleepord Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Walter Richard Peltason</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-1905</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>14</u> Hours <u></u> Min <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		12. KIND OF BUSINESS OR INDUSTRY <u>optical co.</u>	
13. BIRTHPLACE (State or foreign country) <u>Germany</u>		14. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
15. FATHER'S NAME <u>Richard Peltason</u>		16. MOTHER'S MAIDEN NAME <u>Rudolfine Eppner</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>212-38-4012</u>	
19. INFORMANT <u>Maryanne Peltason - Stem 2</u>		20. ADDRESS <u></u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic acidosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) <u></u>	
23. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	24. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	26. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
27. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		28. DATE THEREOF <u>3/9/59</u>	
29. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		30. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
31. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		32. ADDRESS <u>Bethesda, Maryland</u>	
33. REC'D BY REGISTRAR <u>MAR 9 '59</u>		34. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



3363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Republic			
				d. STREET ADDRESS Scientists' Cliffs			
3. NAME OF DECEASED (Type or print) First William Middle Wesley Last Peter				4. DATE OF DEATH Month March Day 31 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 6, 1882	
				9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Henry Peter				14. MOTHER'S MAIDEN NAME Alvina Parman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. 578-48-2494		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest and ventricular fibrillation DUE TO Status postoperative - resection of duodenum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last arterial aneurysm, ruptured DUE TO Generalized severe arteriosclerosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe interstitial pulmonary emphysema INTERVAL BETWEEN ONSET AND DEATH 30 hrs. years							
MEDICAL CERTIFICATION 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 30, 1959 to March 31, 1959 , that I last saw the deceased alive on March 31, 1959 and that death occurred at 5:40 P M, from the causes and on the date stated above ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-1-59 ACTUAL SIGNATURE Robert D. Bloodwell M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Robert D. Bloodwell Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		Apr. 3, 1959		Cedar Hill		Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harker				ADDRESS 1400 Mutual, Md		24a. REC'D BY REGISTRAR DATE APR 6 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 11, 12, 13, 14, 15, 16-59 et

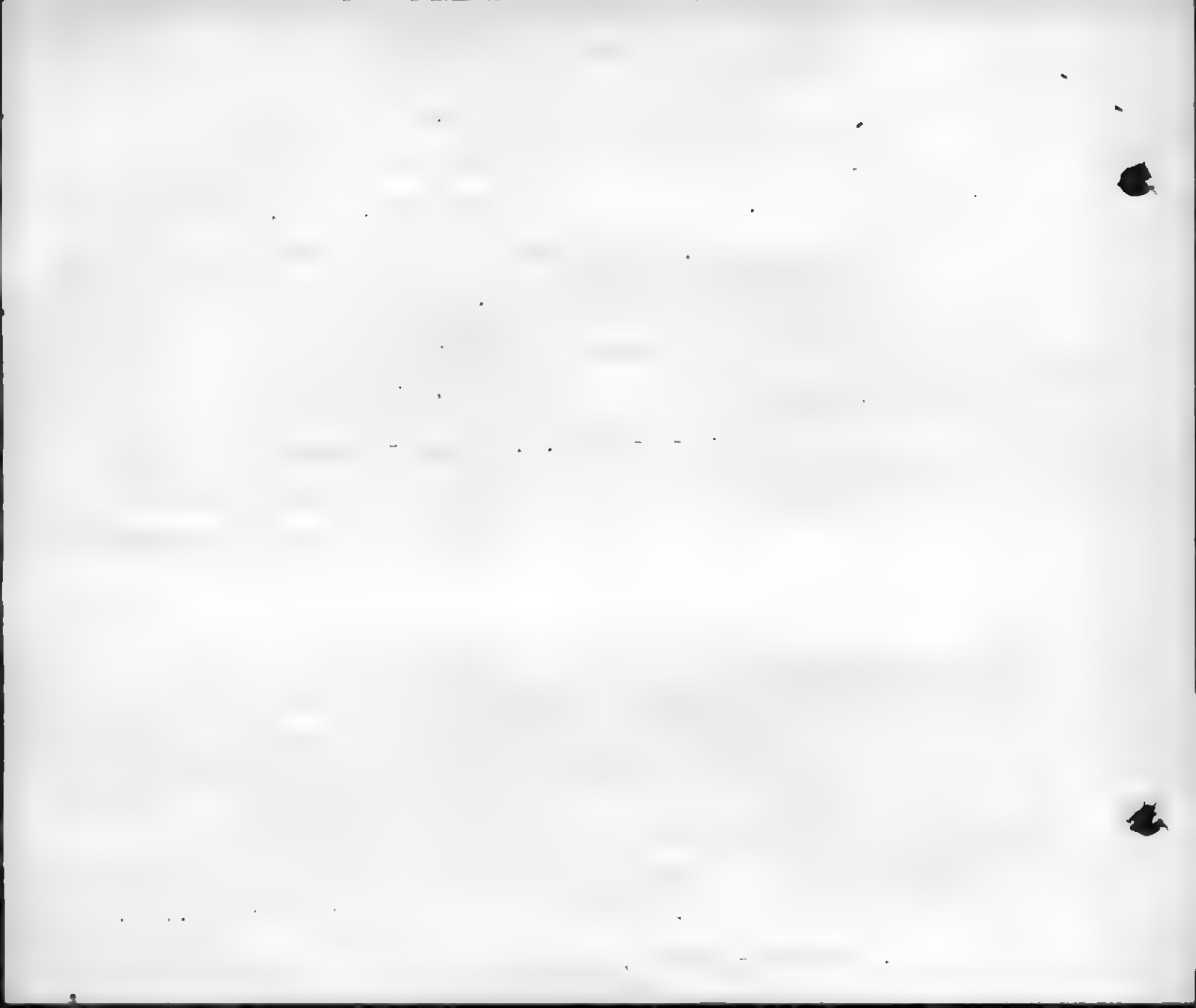
CERTIFICATE OF DEATH

03345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b X Kensington			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3002 Kensington Blvd.				d. STREET ADDRESS 3002 Kensington Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last AMANDA M. PHILLIPS				4. DATE OF DEATH Month Day Year March 7, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1879	
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Thomas T. Collins				14. MOTHER'S MAIDEN NAME Mary T. Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-03-8561		17. INFORMANT Address E. A. Phillips - Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Chronic Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Severely DUE TO Severely DUE TO Severely							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1/59 1955 19 , to 3/7/59 , 19 , that I last saw the deceased alive on 3/1/59 , 19 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, Md. DATE SIGNED 3/7/59							
ACTUAL SIGNATURE Samuel Allen				PHYSICIAN'S NAME (Type) SAMUEL ALLEN, M.D. Kensington			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 3/9/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03346

Reg. Dist. No.

3365

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MASS.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUINCY</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 mo</u>		d. STREET ADDRESS <u>117 BUTLER ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10308 Brookmore Dr.</u>		e. <u>XXXXXX XXXXXX XXXXXX XXXXXX</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith Maudie Phinney</u>		4. DATE OF DEATH <u>Mar 16 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR <u>69</u> Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Ernest Bowser</u>		14. MOTHER'S MAIDEN NAME <u>Aminie unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Ethel Whittam (daughter)</u>		Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>TRANSIT & BURIAL</u>		22b. DATE THEREOF <u>3/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WAKEFIELD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WAKEFIELD, MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>MAR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03347

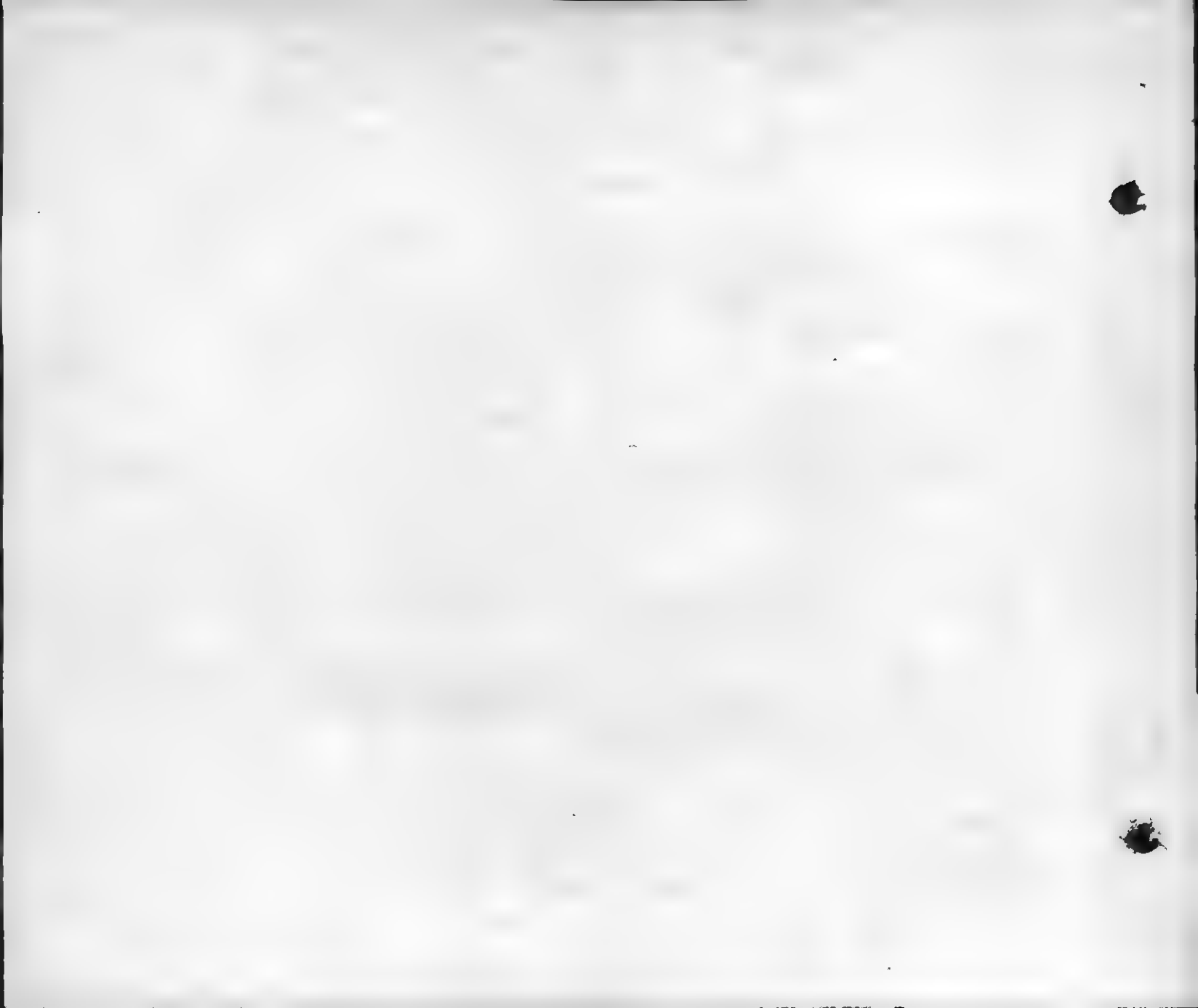
3255

Reg. Dist. No

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs</u>				d. STREET ADDRESS <u>210 E. Montgomery Ave - apt 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. C. Montgomery & Coz - apt 2</u>				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sarah</u> <u>Robert Pumphrey</u>				4. DATE OF DEATH <u>Mar 17 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>2-5-12</u>		9. AGE (in years last birthday) <u>47</u> yrs.	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>refrigeration</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>refrigeration</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Walter Pumphrey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pumphrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>WW 2</u>		17. INFORMANT <u>Betty Pumphrey (wife)</u> Address <u>Sh...</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-17-59</u>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 19 59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur P. K...</u>			

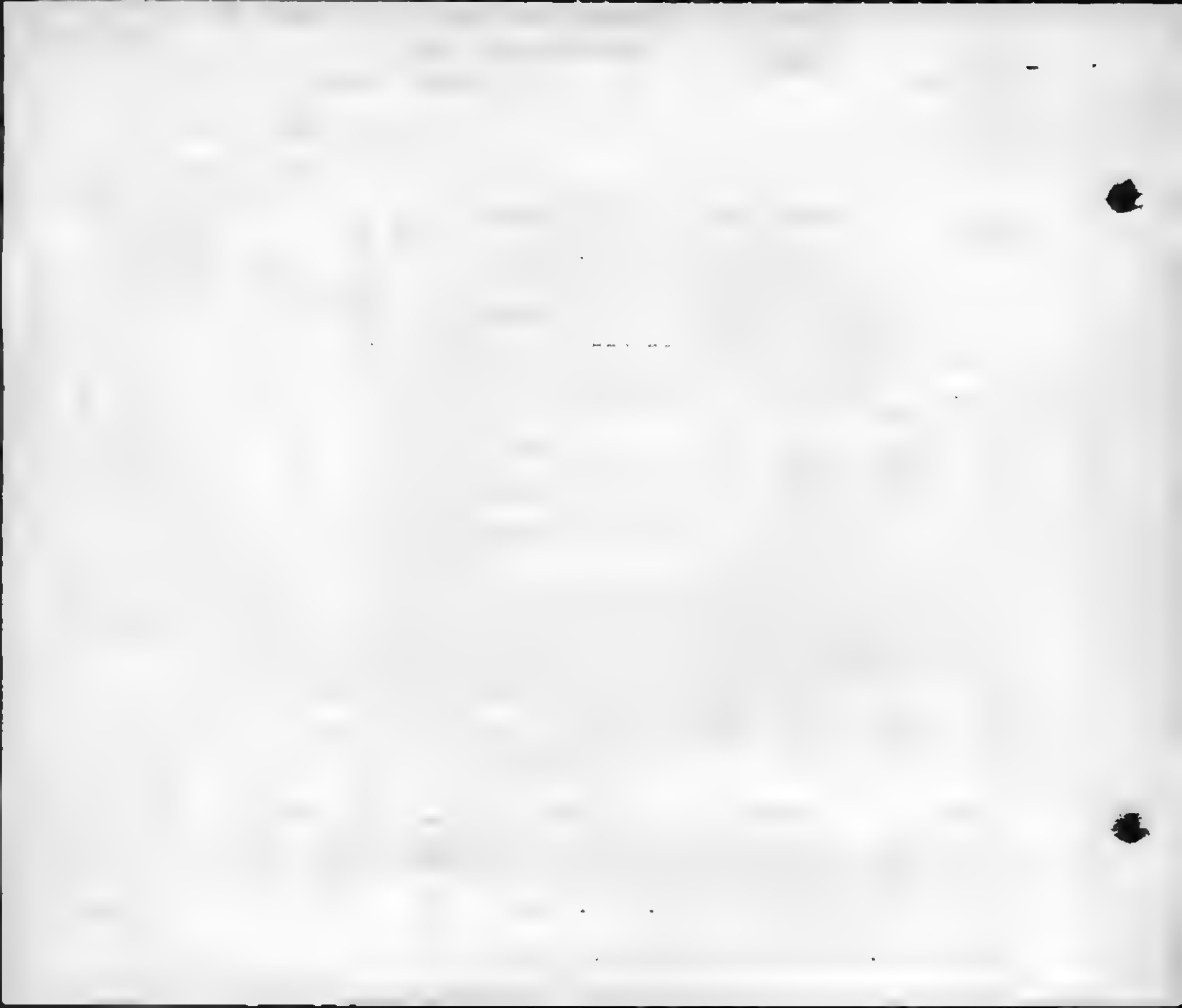


CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XCHEVY CHASE</u>	
c. LENGTH OF STAY IN 1b <u>10 DAYS</u>		d. STREET ADDRESS <u>14422 RIDGE STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL HAMILTON POST</u>		4. DATE OF DEATH Month Day Year <u>MARCH 13 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 23, 1879</u>
9. AGE (in years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. <u>6 20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN BARTON HAMILTON</u>		14. MOTHER'S MAIDEN NAME <u>HAYDEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MR. THEODORE POST</u>		Address <u>113 S. PARK DR. ARLINGTON, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage in lung</u> DUE TO <u>Carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 yrs</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cardiovascular Renal Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 12</u> 19 <u>59</u> to <u>Mar 13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 13</u> 19 <u>59</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4413 Bradley Lane Chevy Chase 15 Maryland</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u> M.D.		PHYSICIAN'S NAME (Type) <u>BRADLEY D. HODGKINS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR <u>DATE MAR 18 '59</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

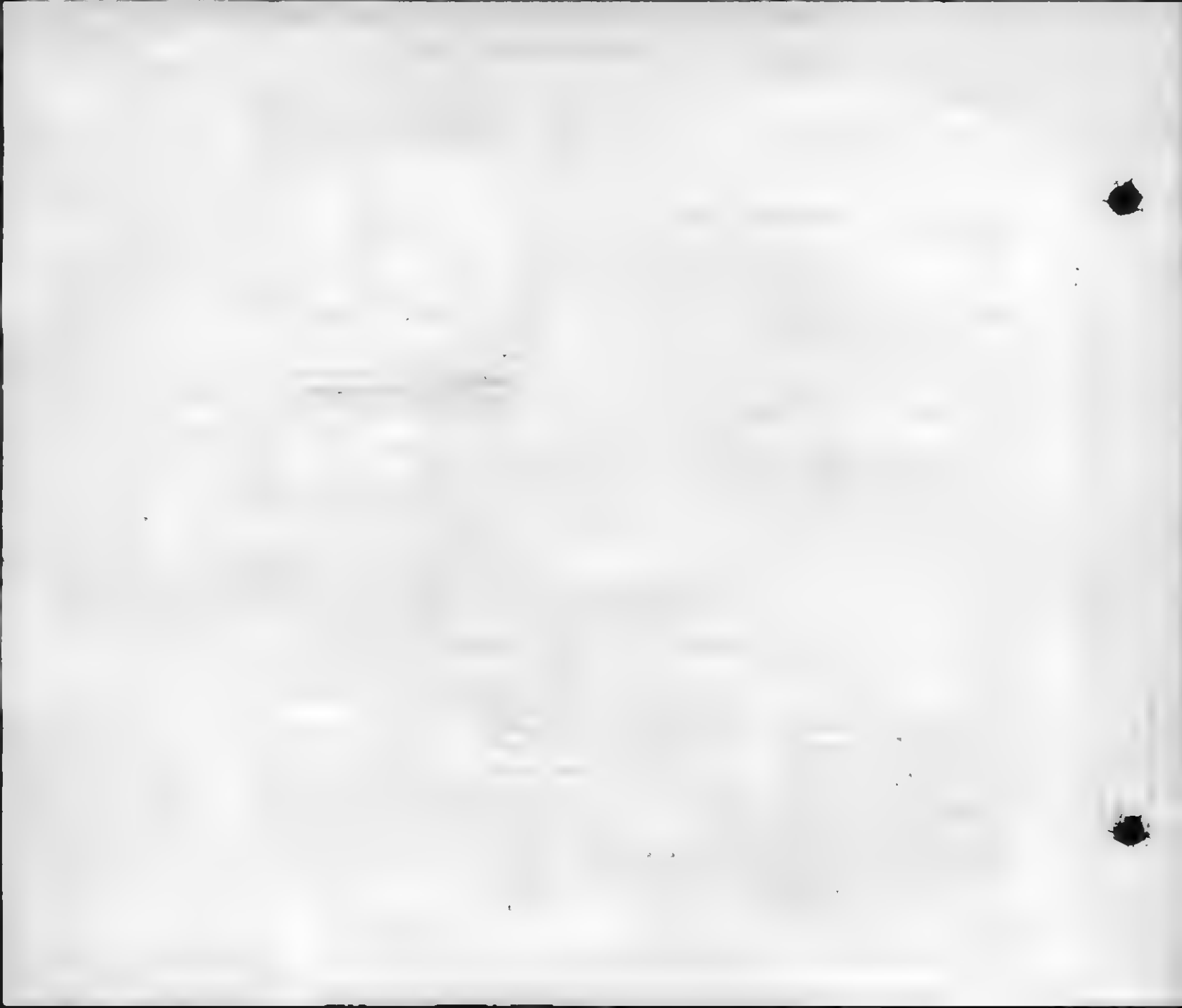
03349

3367

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD2 Gaithersburg</u>				c. LENGTH OF STAY in 1b <u>RD2 Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>RD2 Gaithersburg</u>			
3. NAME OF DECEASED (Type or print) <u>Tobias</u> First <u>(NMI)</u> Middle <u>Prather</u> Last				4. DATE OF DEATH <u>March 10</u> Month <u>10</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, Dairyman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Prather</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Sam Prather, SON</u> Address <u>RD2 Gaithersburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1 Cerebral Embolism, Multiple</u> DUE TO (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2 Days</u> <u>2 Mos.</u> <u>3 mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 15, 1959</u> to <u>Mar. 10, 1959</u> , that I last saw the deceased alive on <u>Mar. 9, 1959</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RD1, Gaithersburg, Md.</u> DATE SIGNED <u>3-10-59</u>							
ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Clive E. Jackson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/14/59</u>		<u>Brooke Grove..</u>		<u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3241

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. STREET ADDRESS <u>3305 Shepherd St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Lucille Pruitt</u>				4. DATE OF DEATH Month Day Year <u>March 1 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1916</u>	9. AGE (In years last birthday) <u>43</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>T. Henry Wunsch</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor S. Kuhn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>451-01-1677</u>		17. INFORMANT Address <u>Admiss. on sheet</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>VIRUS PNEUMONIA WITH SECONDARY PULMONARY ABSCESSES</u> <u>192x</u> DUE TO (b) <u>TOXIC MYOCARDITIS, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CONGESTIVE HEART FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>3 DAYS</u> <u>TERMINAL</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>59</u> , to <u>Mar 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March</u> , 19 <u>59</u> , and that death occurred at <u>9:56 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7835 Eastern Ave, Silver Spring, Md</u> DATE SIGNED <u>Mar 2, 1959</u>							
ACTUAL SIGNATURE <u>George L Ball</u>		M.D. <u>7835 Eastern Ave, Silver Spring, Md</u>					
PHYSICIAN'S NAME (Type) <u>George L Ball</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 3, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>			24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3368

CERTIFICATE OF DEATH

03351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>19 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1 10112 Childs Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>M.</u> Last <u>Rapuano</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/23</u>		9. AGE (In years lost birthday) <u>35</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin M. Rapuano</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Fasano</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Rose M. Rapuano</u>		Address <u>10112 Childs Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>Librarchard Lennorhays</u> 1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27 19 59</u> to <u>March 28 19 59</u> , that I last saw the deceased alive on <u>March 27 19 59</u> , and that death occurred at <u>3:21 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>1904 R L H</u> DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>J.P. MURPHY JR</u> <u>Washington DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/31/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeths Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>St. Leo Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fernald</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

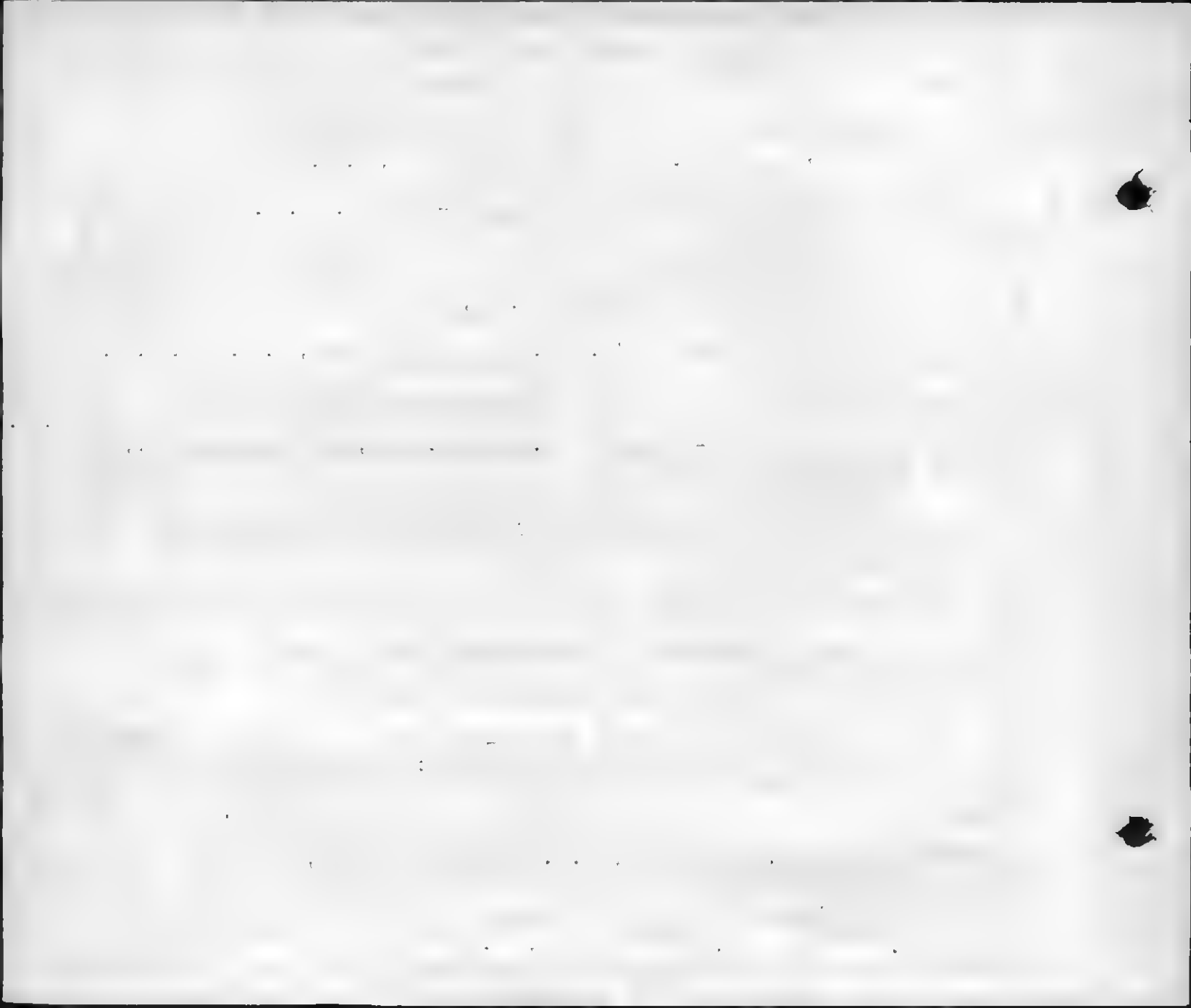
3369

CERTIFICATE OF DEATH

Reg. Dist. No.

03352

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,				c. LENGTH OF STAY IN 1b Feb. 19, 1959			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES OWEN REED				4. DATE OF DEATH Month Day Year March 4 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 21, 1880	
9. AGE (In years last birthday) 79 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL ENGINEER (retired)		10b. KIND OF BUSINESS OR INDUSTRY NAT'L. ELEC. SUPPLY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE WASHINGTON REED		14. MOTHER'S MAIDEN NAME MARY EMMA EDMONSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 677-05-6348		17. INFORMANT Address MRS. JAMES W. GILL, 9213 COLUMBIA BLVD., SILVER SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Arrhythmia Auricular Tachycardia DUE TO (c) 24 Hours				INTERVAL BETWEEN ONSET AND DEATH 48 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan Feb 20-59 to Mar 4 1959 , that I last saw the deceased alive on Mar 3 1959 , and that death occurred at 12:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St. DATE SIGNED ACTUAL SIGNATURE Robert T. Thibadeau M.D. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 6, 1959		22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

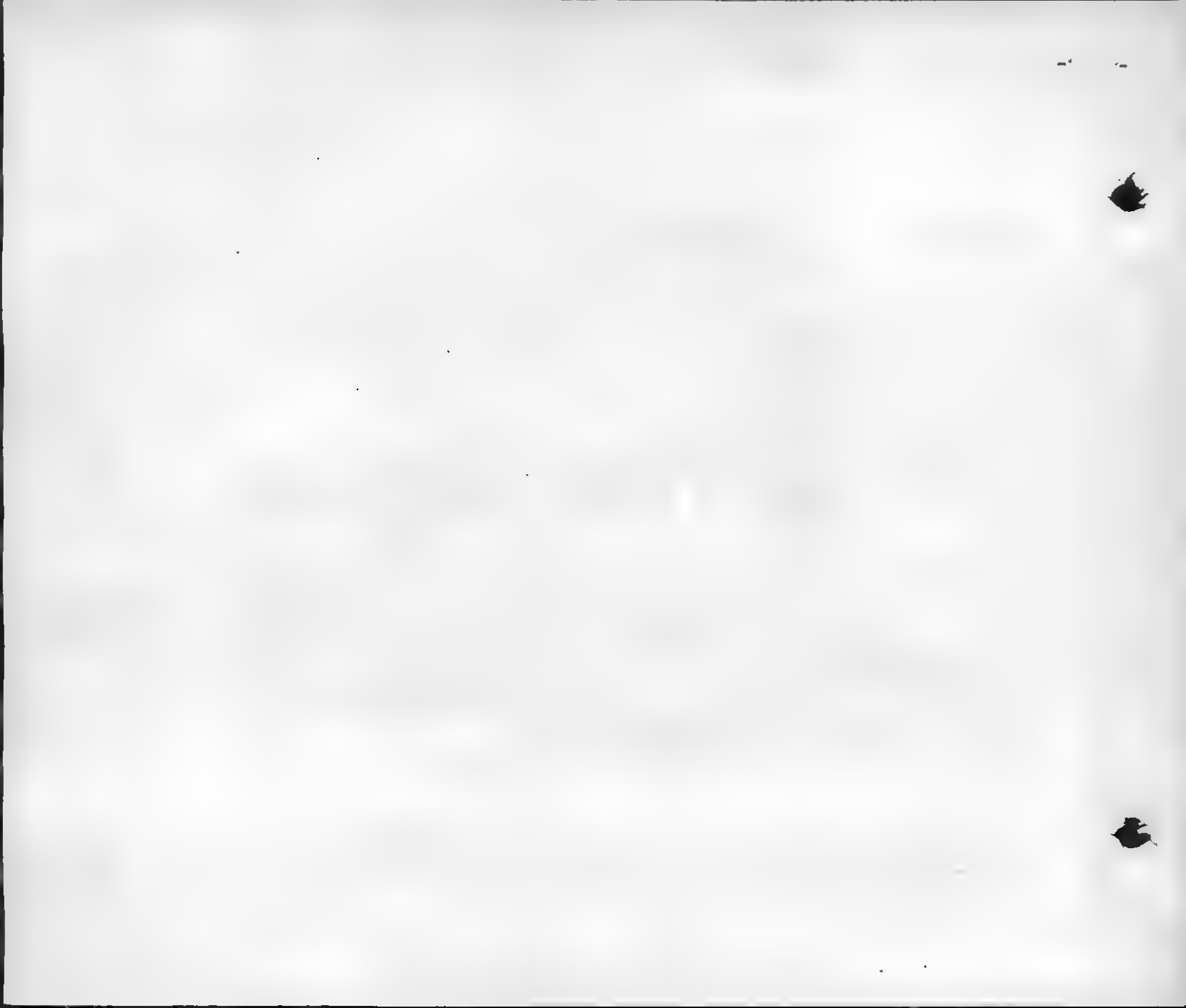
03353

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5502 Burlington Court</u>	
3. NAME OF DECEASED (Type or print) <u>Wilber Jackson Reed Jr.</u>		4. DATE OF DEATH <u>March 17 1945</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17 1945</u>	
9. AGE (In years, last birthday) <u>13</u> yrs		10. IF UNDER 1 YEAR <u>11</u> Months <u>26</u> Days	
11. IF UNDER 24 HRS <u>11</u> Hours <u>26</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilber Jackson Reed Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Jane Foster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Wilber J. Reed, Sr.</u>		Address <u>same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Purp. & Tox. & bronchitis</u> <u>500 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item (8))	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschatt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>FRANK J. Broschatt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-14-53</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>BAMAR 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03354

3242

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>4</u>		
b. CITY OR TOWN (If parts of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>			d. STREET ADDRESS <u>3634 Albermarle St. NW</u>		
3. NAME OF DECEASED (Type or print) <u>Esther Mindick</u> First Middle Last			4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-1869</u>		9. AGE (in years last birthday) <u>89</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Hostess at Sibley Hosp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Mindick</u>			14. MOTHER'S MAIDEN NAME <u>Elija Cress</u> <u>Mrs Mildred A. Harris (hand lady)</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT <u>Stu</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-29-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LEES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Lee</u>		ADDRESS <u>Wish D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



3371

CERTIFICATE OF DEATH

Reg. Dist. No.

03355

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>3503-E Woodbine</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>T</u> Last <u>REITH</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1868</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dress maker</u>	11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William A Reith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rose Caspar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Ther Ryland Joyner</u> Address <u>3503 Woodbine St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>30 YR</u> DUE TO (c) <u>HYPERTENSIVE HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCT 15</u> , 19 <u>54</u> , to <u>MAR 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAR 7</u> , 19 <u>59</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1714 RI AVE NW WASHINGTON DC</u> DATE SIGNED <u>ARTHUR H. LEWIS</u>			
ACTUAL SIGNATURE <u>Arthur H Lewis</u> M.D.		PHYSICIAN'S NAME (Type) <u>ARTHUR H. LEWIS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>
22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Severe Sons Co</u> ADDRESS <u>3605-14 St NW Wash DC</u>		24a. REC'D BY REGISTRAR <u>MAR 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur H. Lewis</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3372

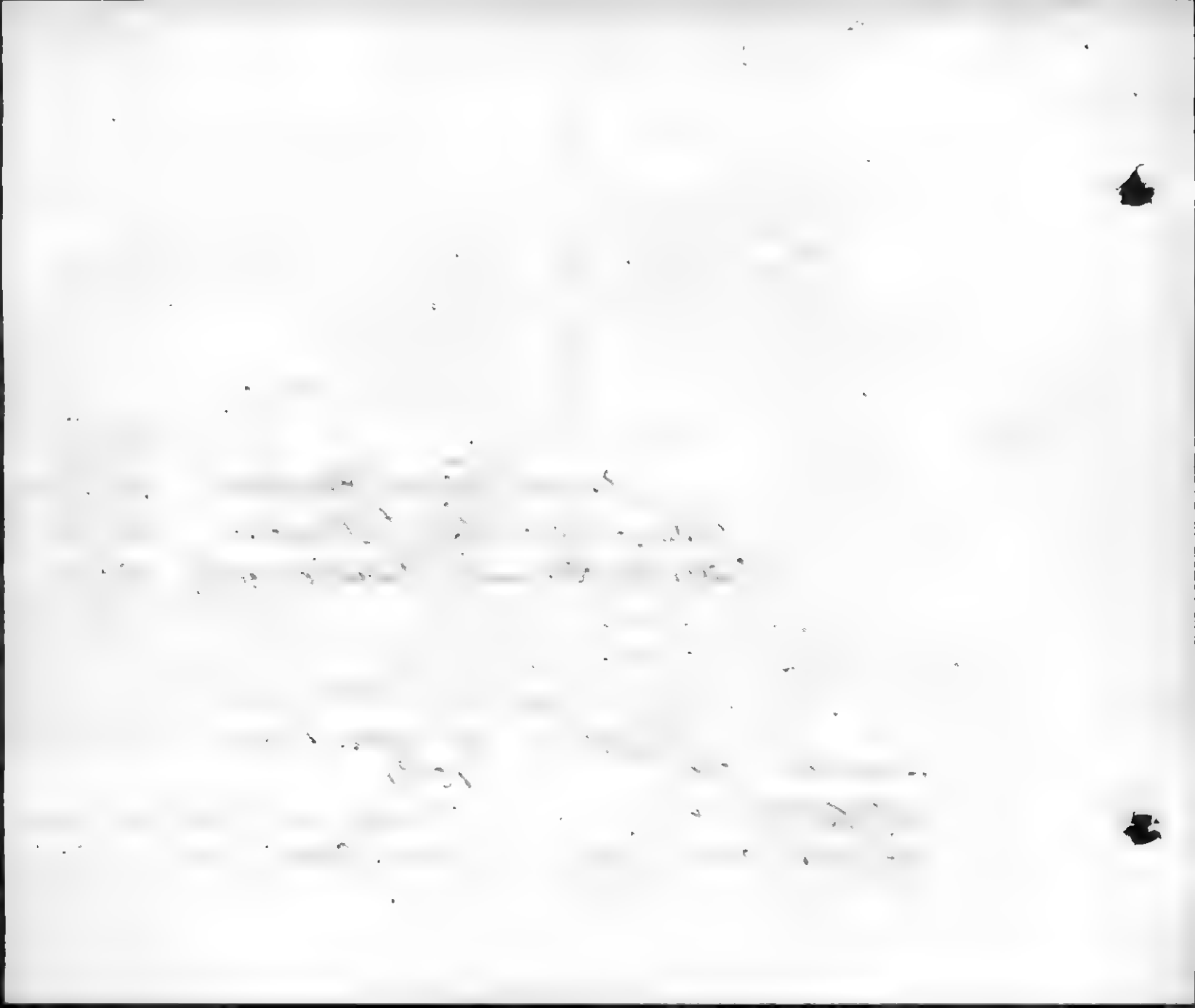
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admision) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4908 Cushing Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA G. RICE		4. DATE OF DEATH March 11 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1879
9. AGE (in years last birthday) 79 yrs		10. IF UNDER 1 YEAR 8 Months 5 Days 11 Hours 59 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Albert Rice		14. MOTHER'S MAIDEN NAME Katherine Tidler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Cherry Chase, Md.		18. ADDRESS Kenneth L Rice-son-7004 Bybrook Lane	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure DUE TO Arteriosclerotic heart disease DUE TO Valvular Rheumatic Cardiomegaly DUE TO ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		INTERVAL BETWEEN ONSET AND DEATH 10 min. 5+yr. 10+yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year June 19 59 Hour 10 min 30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----	
21. I certify that I attended the deceased from 20 June 19 59 to 11 March 59 , that I last saw the deceased alive on 6 March 59 , and that death occurred 10:30 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE A.H. Richwine M.D.		DATE SIGNED 5522 WESTERN AVE 12 MAR 1959	
PHYSICIAN'S NAME (Type) A.H. RICHWINE		ADDRESS CHERRY CHASE MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/59	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03357

3373

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Federick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blaney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>		d. STREET ADDRESS <u>R.F. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Leslie Riggs</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James Riggs</u>		14. MOTHER'S M maiden name <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-38-9665</u>	17. INFORMANT <u>Laura Burke (daughter)</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Was driver of car involved in auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:20 p.m. 3-11-1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Kemptown montg md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Providence Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Kemptown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Molnar</u>		24a. REC'D BY REGISTRAR <u>MAR 16 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No

03358

3374

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b BETHESDA d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5800 Ryland Drive		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 5800 Ryland Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE M RINEHART		4. DATE OF DEATH Month March Day 22 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1883
9. AGE (In years last birthday) yrs 75		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 9 Days 21 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Mooney		14. MOTHER'S MAIDEN NAME Sarah Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) None	
17. INFORMANT Son		Address Albert Rinehart-5931 Beech Av., Bethesda	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		INTERVAL BETWEEN ONSET AND DEATH 20 MINUTES 10 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1, 1954 to MARCH 22, 1959 , that I last saw the deceased alive on MARCH 22, 1959 , and that death occurred at 12:30 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Joseph P. Connor		ADDRESS (Street, city or town, state) 9420 OLD GEORGETOWN ROAD, BETHESDA 14, MARYLAND	
PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR		DATE SIGNED MARCH 22, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/59	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE MAR 24 '59	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

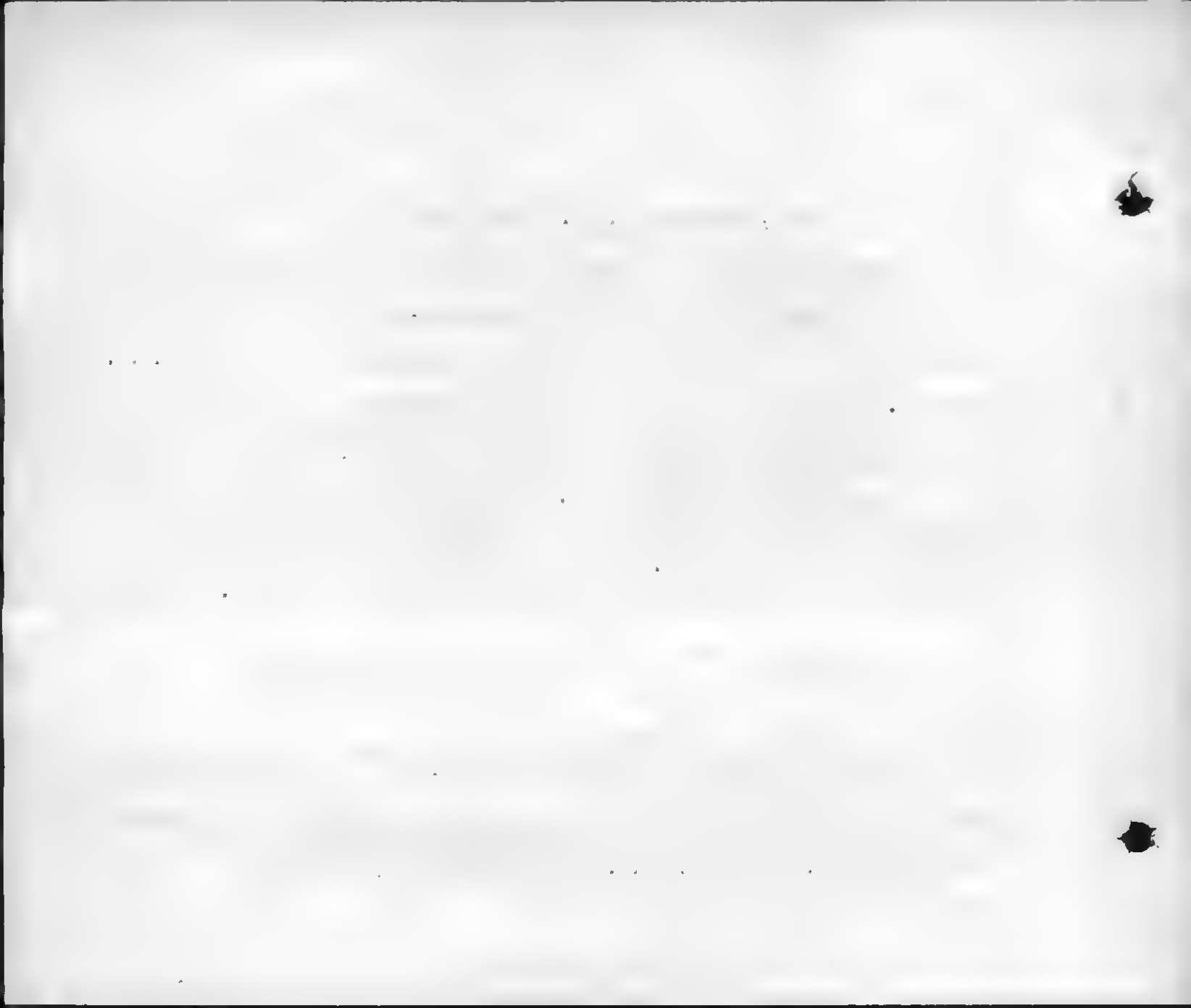
3375

CERTIFICATE OF DEATH

Reg. Dist. No.

03359

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>New Jersey</u> b COUNTY <u>Camden</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c LENGTH OF STAY IN 1b <u>34 days</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e STREET ADDRESS <u>751 Spruce Street</u>			
3 NAME OF DECEASED (Type or print) First <u>Marianne</u> Middle <u>(None)</u> Last <u>Robinson</u>				4 DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>19 59</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negroe</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>February 9, 1943</u>		9 AGE (In years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Howard G. Robinson</u>				14 MOTHER'S MAIDEN NAME <u>Ethel Troutman</u>			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congenital Heart Disease, Ventricular Septal Defect.</u> DUE TO (c) <u>Status Postop - Decortication of Right Lung.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 22, 19 59</u> to <u>March 28, 19 59</u> , that I last saw the deceased alive on <u>March 28, 19 59</u> , and that death occurred at <u>7:12a</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Robert D. Bloodwell</u>		M.D. <u>The Clinical Center</u>		DATE SIGNED <u>3/28/59</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>ROBERT D. BLOODWELL, M.D.</u>		National Institutes of Health		Bethesda 14, Maryland			
22a BURIAL, CREMATION, or other disposal (Specify) <u>Burial 4-1-59</u>		22b DATE THEREOF <u>4-1-59</u>		22c NAME OF CEMETERY OR CREMATORY <u>Olivet</u>		22d LOCATION (City, town, or county) (State) <u>Camden, N.J.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Mad. Ave.</u>		24a REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>	
				24b REGISTRAR'S SIGNATURE <u>Arthur S. Fraw</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

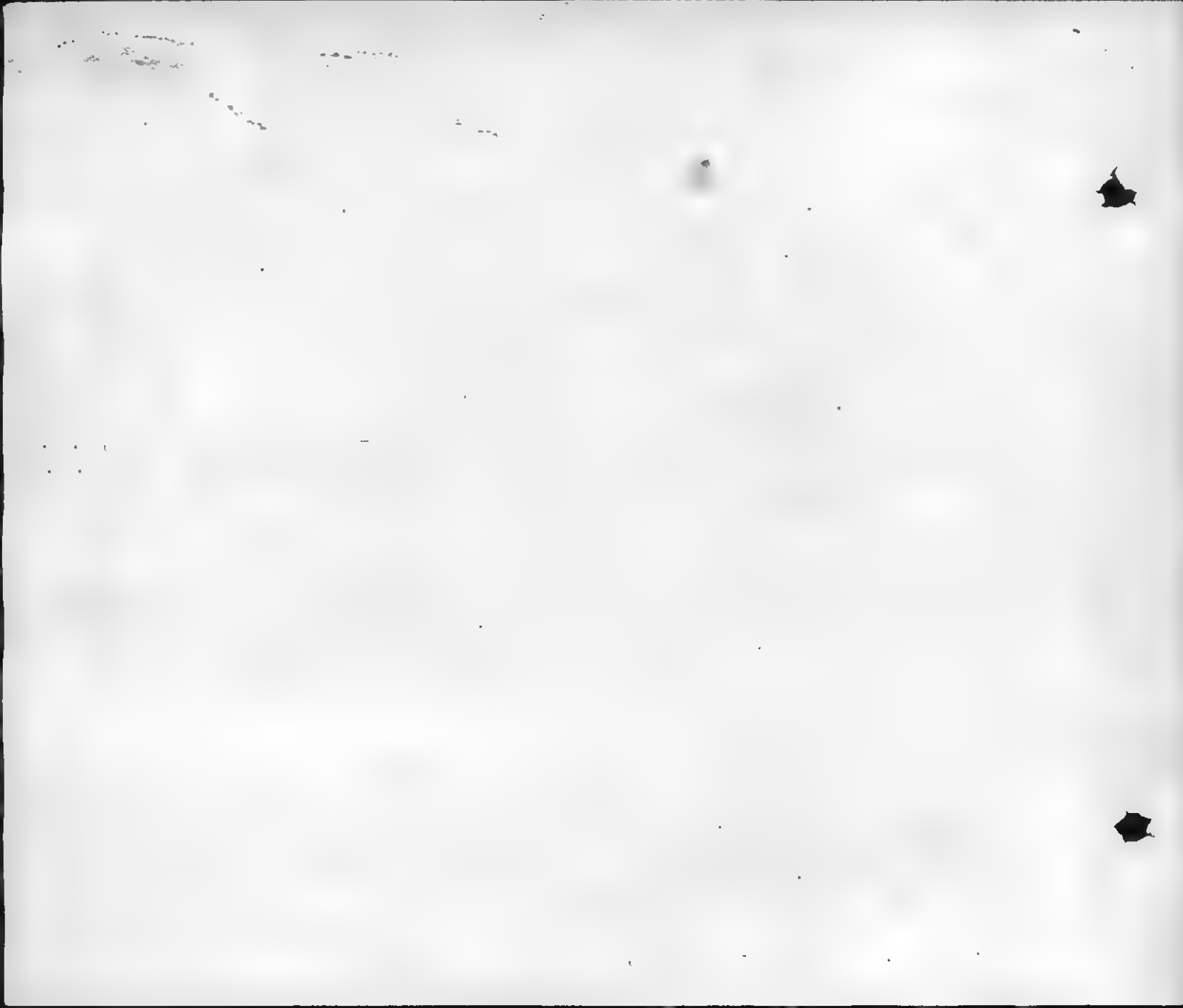
3376

Reg. Dist. No.

03360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4503 Elm St.</u>		f. STREET ADDRESS <u>4503 Elm St.</u>	
3. NAME OF DECEASED (Type or print) <u>Eloise N. Rockwell</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u>	
11. IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby sitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis B. Newman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Murphy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>563-07-9098</u>	
17. INFORMANT <u>Louella Newman-Shelton Towers Hotel, N. Y. 17</u>		Address <u>N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in nude on bed in basement home. Had been dead a week or more when found.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>3/25/59</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 31 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>			

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

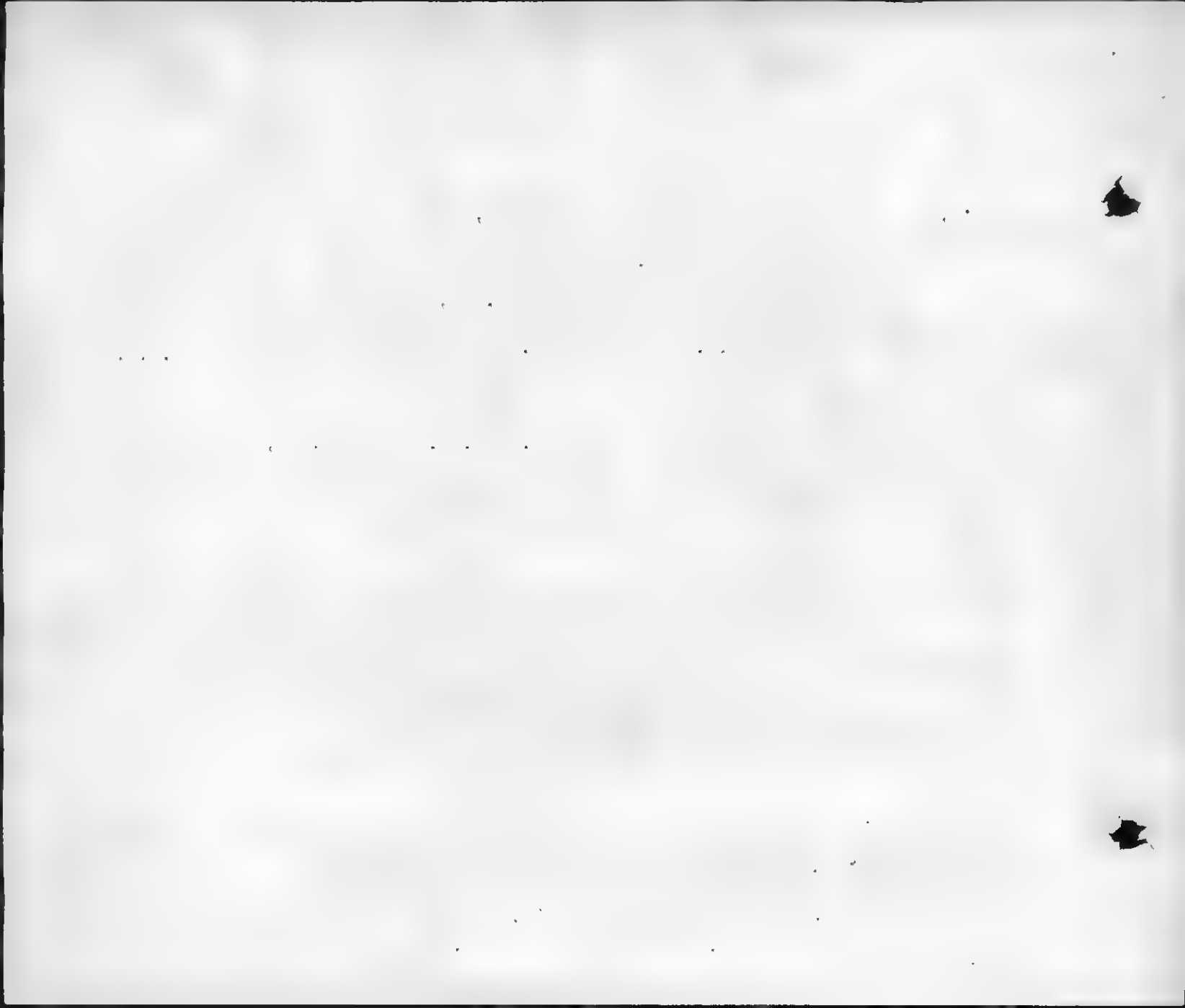
03361

3377

Reg Dist No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,613 MEADOWOOD DRIVE						d. STREET ADDRESS 12,613 MEADOWOOD DRIVE					
3. NAME OF DECEASED (Type or print) BESSIE		First E.		Middle ROTHWELL		Last		4. DATE DEATH		Month MARCH	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 27, 1889		9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 17 Days 19 Years 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Treasury Dept.				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Shuler						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW #1				16. SOCIAL SECURITY NO none		17. INFORMANT Mr. Geo. W. Rothwell, 12,613 Meadowood Drive Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) FOUND DEAD DUE TO (c) IN BED											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/17/59					
EXAMINER'S NAME (Type) FRANK J. BROSCART						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/19/59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond H. Ziska						ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR MAR 19 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

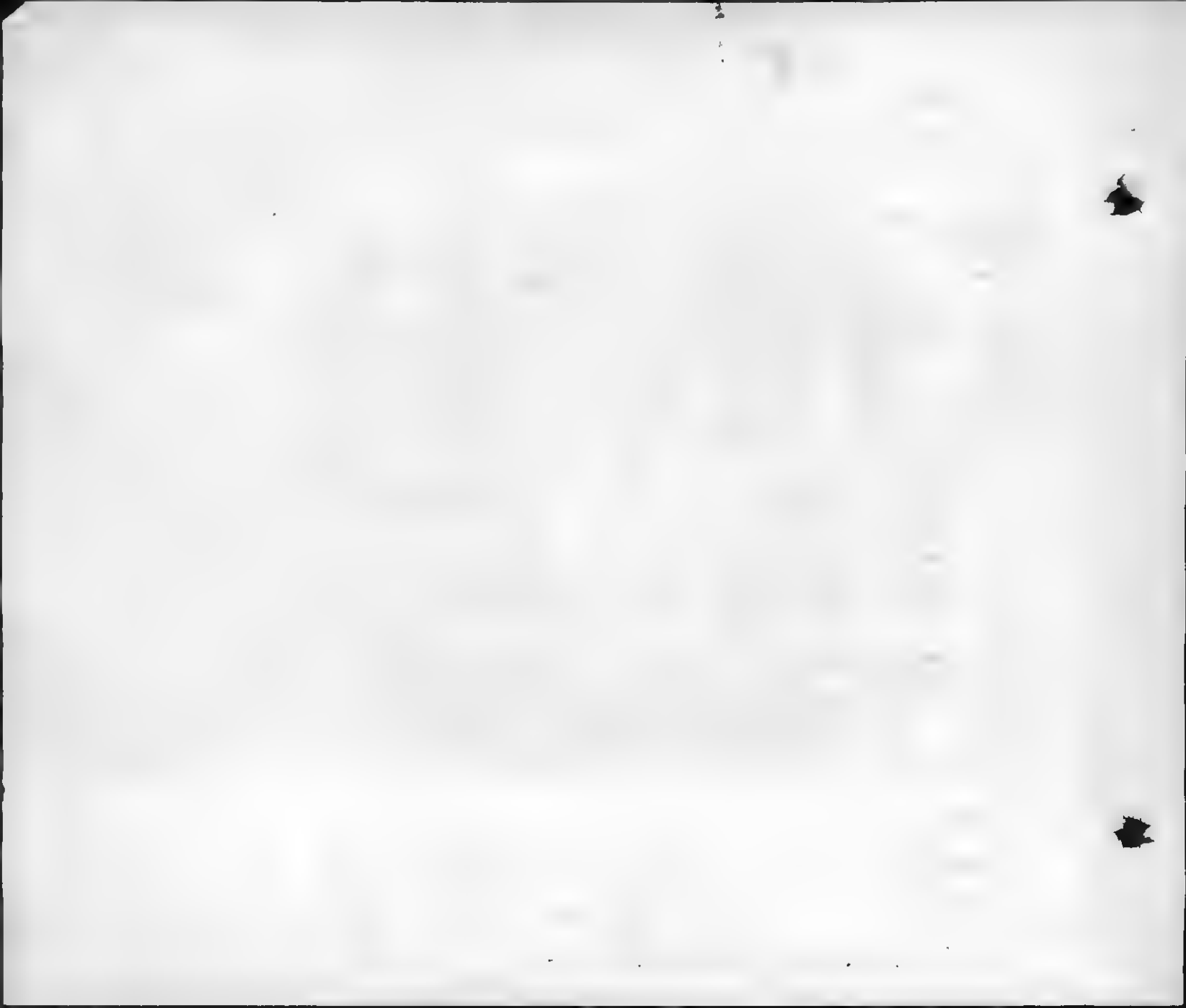
Reg. Dist. No.

0336

3378

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>.C.</u> b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>sninton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Urban Hospital</u>			e. STREET ADDRESS <u>2145 Decatur 1., N.W.</u>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Carson</u> Last <u>Roy</u>			4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1959</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-80</u>		9. AGE (In years last birthday) <u>78</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Walter Roy</u>			14. MOTHER'S MAIDEN NAME <u>Martha Cook</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO _____		17. INFORMANT <u>Cousin-Mary M. Donaldson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>					<u>2 hrs.</u>
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) <u>Shock</u>					<u>1 1/2 days</u>
DUE TO					
(c) <u>Fracture of left hip</u>					<u>1 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell on floor at home</u>			
20c. TIME OF INJURY Month, Day, Year <u>12-30-58</u> <u>3-30-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Washington</u>	(County) <u>DC</u>	(State) <u>DC</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bloesch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-31-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Bloesch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Front Royal, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Tamm</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH o. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		g. STREET ADDRESS <u>8608 Flower Avenue</u>	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Edward</u> Last <u>Ruppert</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-90</u>
9. AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Contr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Ruppert</u>		14. MOTHER'S MAIDEN NAME <u>Beth Louise Koch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-32-1601</u>	
17. INFORMANT <u>Sam-Edwin K. Ruppert</u>		Address <u>3924 N. 1st St. Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INSUFFICIENCY</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <u>FRESH MYOCARDIAL INFARCTION</u> DUE TO (c) <u>Coronary arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>12 days</u> <u>6 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> to <u>March 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 11</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P. M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring, Md</u> DATE SIGNED <u>March 11</u>			
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.		DATE SIGNED <u>March 11</u>	
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>MAR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3379 CERTIFICATE OF DEATH

03364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Reesor Sanatorium, 5721 Groseclose Rd</i>				d. STREET ADDRESS <i>Box 110 R.F.D. #2</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Barbara Black Sabine</i>		First Middle Last		4. DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 9 1918</i>	
9. AGE (In years last birthday) <i>40 yrs</i>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Bohemia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>(Son) George W. Sabine, Box 110 R.F.D. #2 Gaithersburg, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>LEUKEMIA</i> DUE TO <i>DOX</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>METASTATIC CARCINOMA</i> DUE TO (c) <i>CARCINOMA, LEFT BREAST</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/25/1959</i> to <i>3/7/1959</i> , that I last saw the deceased alive on <i>3/7/1959</i> , and that death occurred at <i>6:40 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles J. Savarese</i>		M.D.		ADDRESS (Street, city or town, state) <i>4890 WATTEY LA.</i>		DATE SIGNED <i>3/7/59</i>	
PHYSICIAN'S NAME (Type) <i>CHARLES J. SAVARESE JR. M.D.</i>				<i>6-TH SDA 14 RD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/7/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Ann's</i>		22d. LOCATION (City, town, or county) (State) <i>Gaithersburg Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Prof. W. Barber Day</i>		ADDRESS <i>1000 N. ...</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3380

CERTIFICATE OF DEATH

Reg. Dist. No. 03305

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3931 OLIVER ST.</u>		1 d. STREET ADDRESS <u>3931 OLIVER ST</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Saunders</u> Last <u>Saunders</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LEGAL (GOVT)</u>	11. BIRTHPLACE (State or foreign country) <u>MAINE</u>
13. FATHER'S NAME <u>George F. Saunders</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Donnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1947</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>William P. Saunders 101 Bluff View Lane Luthersville, Ill.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA; RECURRENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>18 MOS.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY FIBROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH, 1958</u> , to <u>MAR. 17, 1959</u> , that I last saw the deceased alive on <u>MAR. 17, 1959</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Twohy</u>		ADDRESS (Street, city or town, state) <u>7720 WISC. AVE, BETHESDA, MD.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. TWOHY</u>		DATE SIGNED <u>5/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>3-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawler's Sons</u>		ADDRESS <u>1750 Pa. Ave. NW</u>	24a. REC'D BY REGISTRAR <u>MAR 19 59</u>
		24b. REGISTRAR'S SIGNATURE <u>William S. Kneave</u>	



3381

CERTIFICATE OF DEATH

Reg. Dist. No.

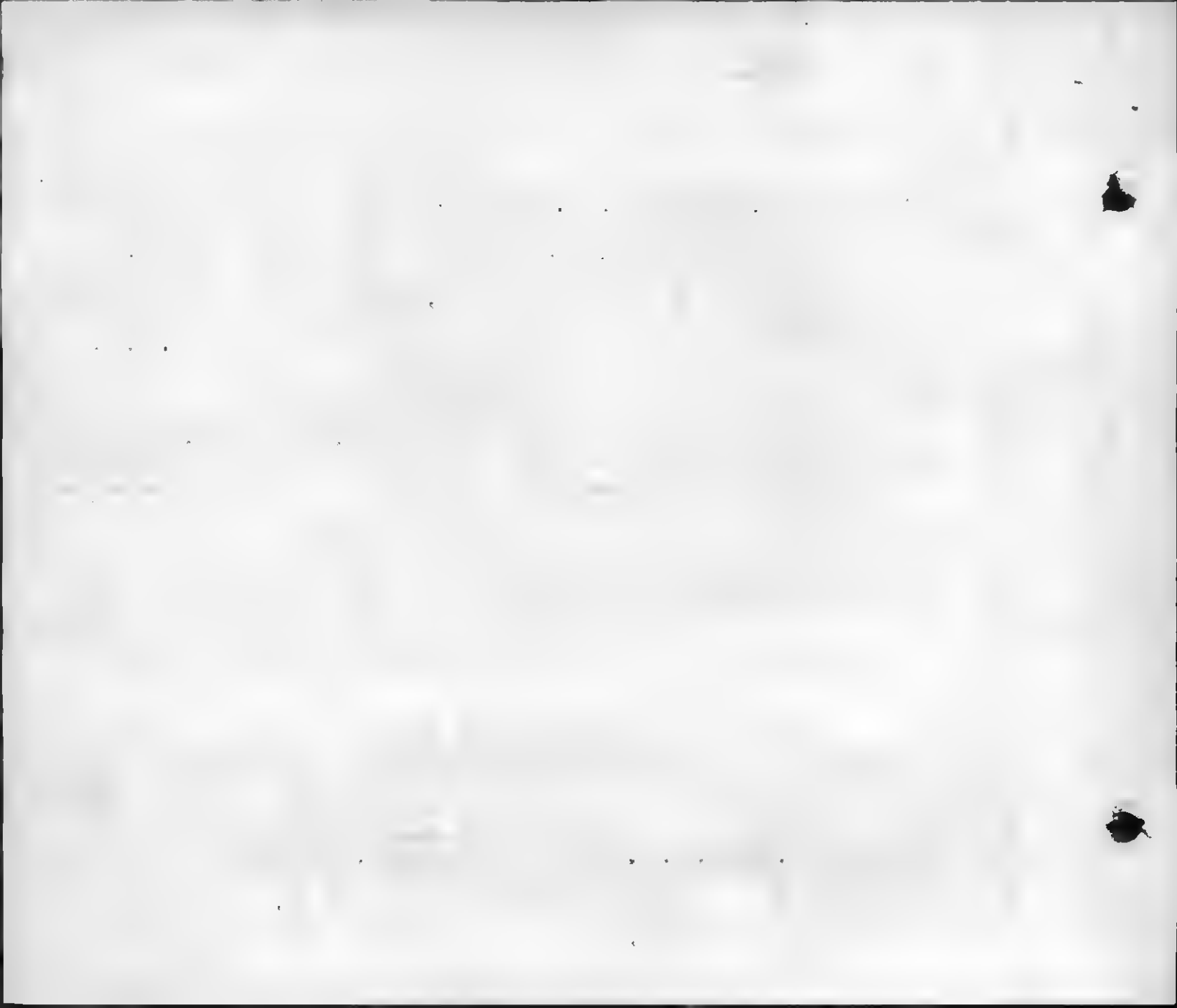
1. PLACE OF DEATH o COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE New York b. COUNTY Wellsville			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 51 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 52 George Street			
3. NAME OF DECEASED (Type or print) First Ida Middle Elizabeth Last L. Sherwood				4. DATE OF DEATH Month March Day 8 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1891	
9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR: Months 6 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Iowa				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Elon Spencer				14. MOTHER'S MAIDEN NAME Eva Moon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Leukemia							
204.3 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o m p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 16, 1959 , to March 8, 1959 , that I last saw the deceased alive on March 8, 1959 , and that death occurred at 10:02 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James M. Marsh, M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) James M. Marsh, M.D.				DATE SIGNED 3/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Burial				3/9/59			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
Woodlawn Cemetery				Orlando, Fla.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE MAR 11 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3382
CERTIFICATE OF DEATH

03367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN It 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc.		d. STREET ADDRESS 716 Gist Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Nancy Ellen Shorts		4. DATE OF DEATH Month Day Year March 2 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.24.71
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Thompson		14. MOTHER'S MAIDEN NAME Margaret Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 2-march, 1959 , that I last saw the deceased alive on 1-march, 1959 , and that death occurred at 7:05 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William D. Aud M.D.			
PHYSICIAN'S NAME (Type) William D. Aud, M. D.		9006 Colesville Road, Silver Spring, Md.	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial	22b. DATE THEREOF March 4	22c. NAME OF CEMETERY OR CREMATORY St. Johns	22d. LOCATION (City, town, or county) (State) Olney Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03368

Reg. Dist. No

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		d. STREET ADDRESS <u>811 Kennebec Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>811 Kennebec Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <u>Jane Adair Shultz</u> First Middle Last		4. DATE OF DEATH <u>Mar 2 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1919</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Wm Adair Merrill</u>		14. MOTHER'S MAIDEN NAME <u>Flourie Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Donald Shultz</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hanging</u> (c) <u>hanging</u> (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>Interval hanging in bathroom</u> <u>Phone</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hung self by neck in basement of her home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. DATE OF DEATH <u>March 4-1959</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Prince George Co Md.</u>	
22c. LOCATION (City, town, or county) <u>Prince George Co Md.</u>		22d. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll St. N.W. W.C.</u>		24. REC'D BY REGISTRAR <u>Mar 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3383

CERTIFICATE OF DEATH

Reg. Dist. No.

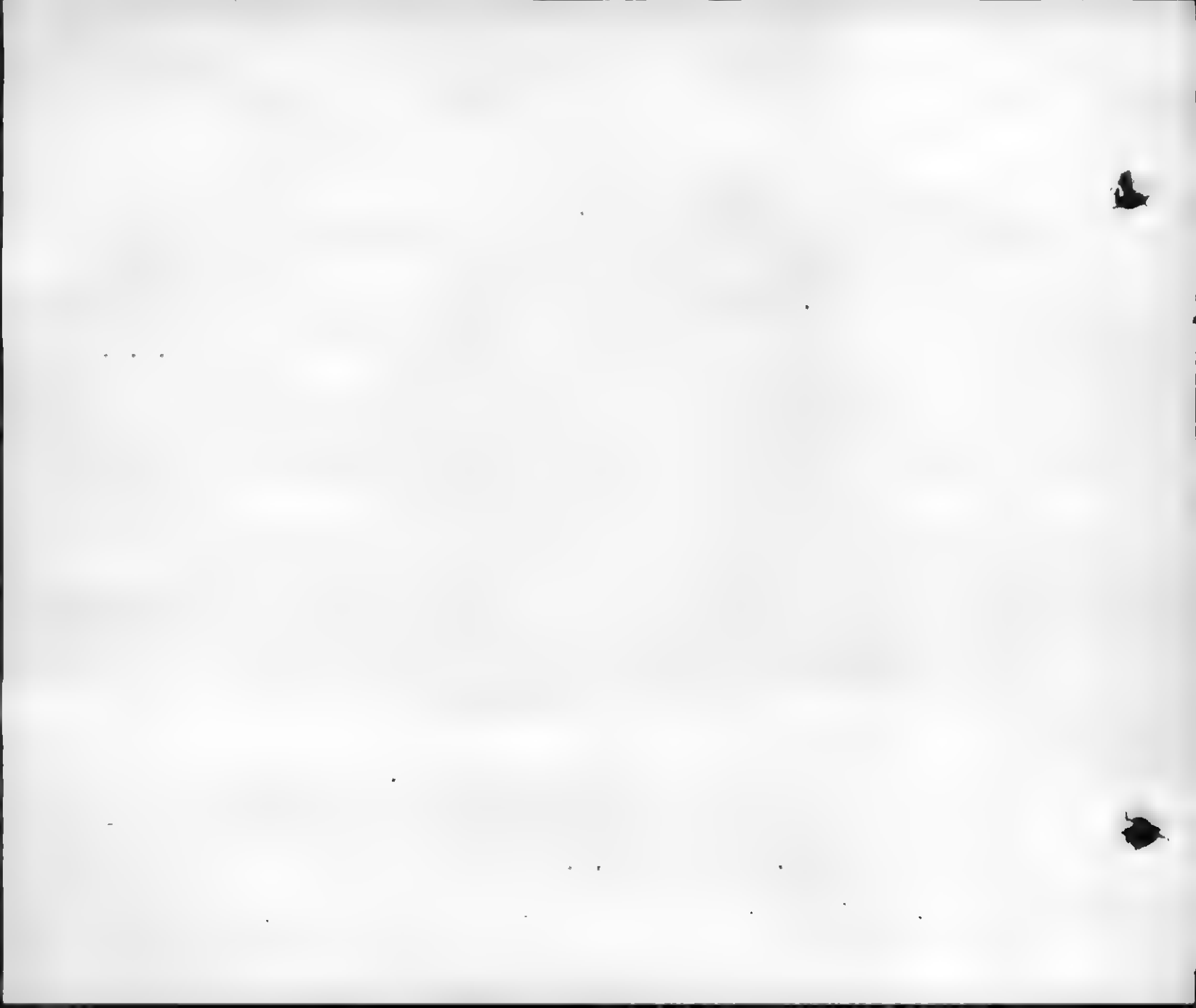
03369

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Cornelius Elester Simms				4. DATE OF DEATH Month March Day 16 Year 1959			
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1924		9. AGE (In years last birthday) 34 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME William Simms				14. MOTHER'S MAIDEN NAME Macey Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address Ethel Simms (wife), Glenwood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcoma of stomach with abdominal metastases DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 18 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October , 19 56 , to March 16 , 19 59 , that I last saw the deceased alive on March 15 , 19 59 , and that death occurred at 11:20 A. M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 3-16-59 ACTUAL SIGNATURE Charles S. Whitaker, M.D. M.D. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-19-59		Trinity Park		Clarksville, Howard, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arthur L. Hight Clarksville, Md.				24a. REC'D BY REGISTRAR DATE MAR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hight	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If not in residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foothillburg</u>		c. LENGTH OF STAY IN 1b <u>10 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foothillburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Muddy Branch Rd</u>			d. STREET ADDRESS <u>Muddy Branch Rd</u>		
3. NAME OF DECEASED (Type or print) <u>Robert Joseph Simpson</u>			4. DATE OF DEATH <u>Mar 14 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1896</u>		9. AGE (in years last birthday) <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Police Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive 3rd degree burn involving</u> DUE TO (b) <u>whole body & extremities</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>sudden</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in living home</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Found dead in living home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1</u>	
		20f. (City or town) <u>Arlington, Va.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-14-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u>	
				22d. LOCATION (City, town, or county) <u>Arlington, Va.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sumner</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3385

CERTIFICATE OF DEATH

03371

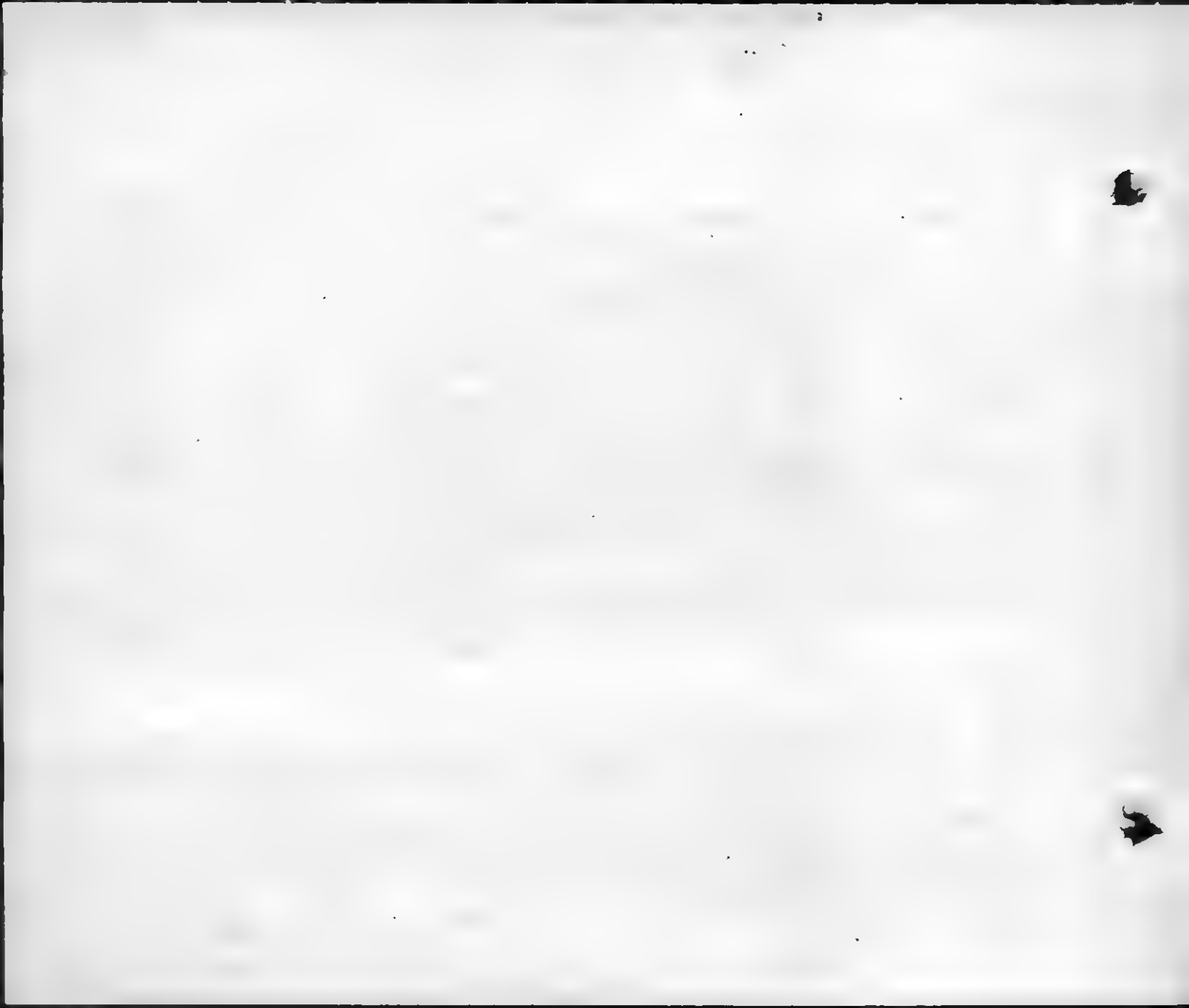
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALL MILKSTONE DR.</u>		e. STREET ADDRESS <u>1000 Milkstone Dr.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY A SIMS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 7 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 9, 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWIN GIBBS</u>		14. MOTHER'S MAIDEN NAME <u>FLEANNOR GARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Address <u>Mrs. KATHLEEN THOMSEN 611 DARTMOUTH ST. SILVER SPRING</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic Carcinoma</u> (c) <u>Adeno Carcinoma - Left Breast</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 yrs</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 6, 1958</u> to <u>March 9, 1959</u> , that I last saw the deceased alive on <u>March 7, 1959</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8248 Georgia ave. 3/9/59</u>	
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>		<u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooklawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Orange, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John E. Lee, 1111 N. Ash St.,</u>		24a. REC'D BY REGISTRAR <u>MAR 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>MONTGOMERY</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN TB <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d STREET ADDRESS <u>8101 3rd Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Ann</u> Last <u>Singer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-87</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>		13. FATHER'S NAME <u>David Siegel</u>	
14. MOTHER'S MAIDEN NAME <u>Gertude UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right hemiplegia, aphasia Hypertension H.D. Urterostomy Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) <u>Hyattsville</u>		(County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>Mar 16, 1959</u> , that I last saw the deceased alive on <u>March 16, 1959</u> , and that death occurred at <u>10:57 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>533 Riggs Rd. N.E.</u>		DATE SIGNED <u>March 19, 1959</u>	
ACTUAL SIGNATURE <u>Arthur S. Bresler</u>		M.D. <u>533 Riggs Rd., N.E.</u>	
PHYSICIAN'S NAME (Type) <u>Arthur S. Bresler, M.D.</u>		<u>533 Riggs Rd., N.E.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Langensky & Sons</u>		ADDRESS <u>3501-14th St N.W. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Bresler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3386

CERTIFICATE OF DEATH

03273

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 4 days				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington d. STREET ADDRESS 5208 Sheriff Road, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William (none) SMITH				4. DATE OF DEATH Month Day Year March 24 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-15-09	
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Greene SMITH				14. MOTHER'S MAIDEN NAME Janie WHITE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) Yes Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with extensive metastases 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6-8 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 20 1959 , to March 24 1959 , that I last saw the deceased alive on March 23 1959 , and that death occurred at 3:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome A. Gold		M.D. U. S. Naval Hospital, NNMC		DATE SIGNED 3-25-59			
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN		Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart's Funeral Home, 30 H St., NE, Wash. DC				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Carlton J. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3387

CERTIFICATE OF DEATH

03374

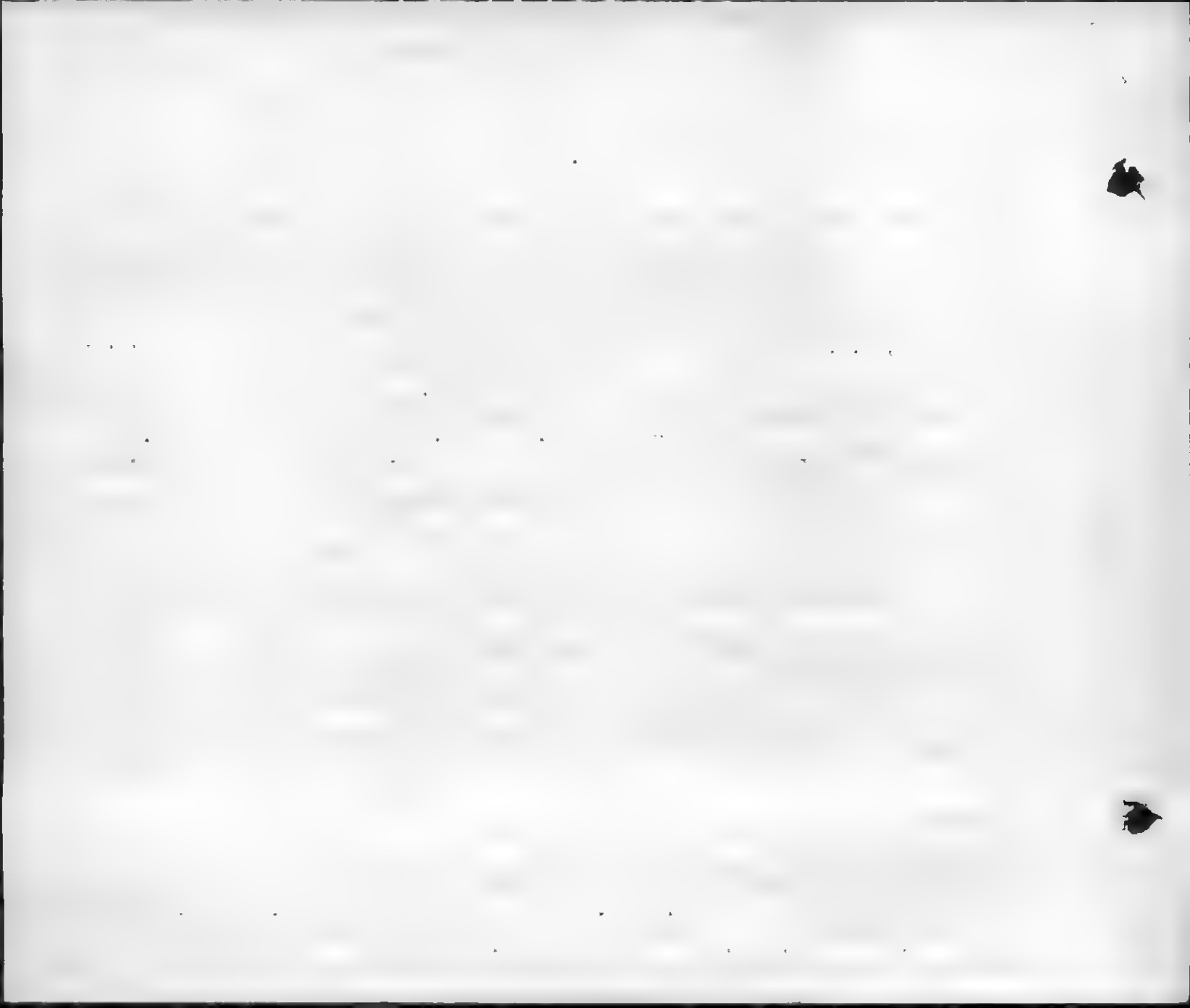
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2107 SEMINARY ROAD				e. STREET ADDRESS 2107 SEMINARY ROAD			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle ADAMS Last STACY				4. DATE OF DEATH Month MARCH Day 21 Year 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/91		9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President, A.A. Stacy & Son Plumbing & Heating		10b. KIND OF BUSINESS OR INDUSTRY Plumbing & Heating		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CEPHAS NEAIE STACY				14. MOTHER'S MAIDEN NAME EMMA C. EDWARDS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 579-10-2719		17. INFORMANT Address Mrs. Essie M. Stacy, 2107 Seminary Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cachexia and Exhaustion DUE TO Carcinoma of Sigmoid c Metastases to Liver							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1959 to March 21, 1959 , that I last saw the deceased alive on March 20, 1959 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Horace H. Custis Jr. M.D. 1852 Columbia Rd NW 361/59				ADDRESS (Street, city or town, state) Washington 9 D.C.			
PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR.				DATE SIGNED 3/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/24/59		22c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		22d. LOCATION (City, town, or county) (State) Prince Geo. County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. Raymond A. Pumphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR MAR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3388

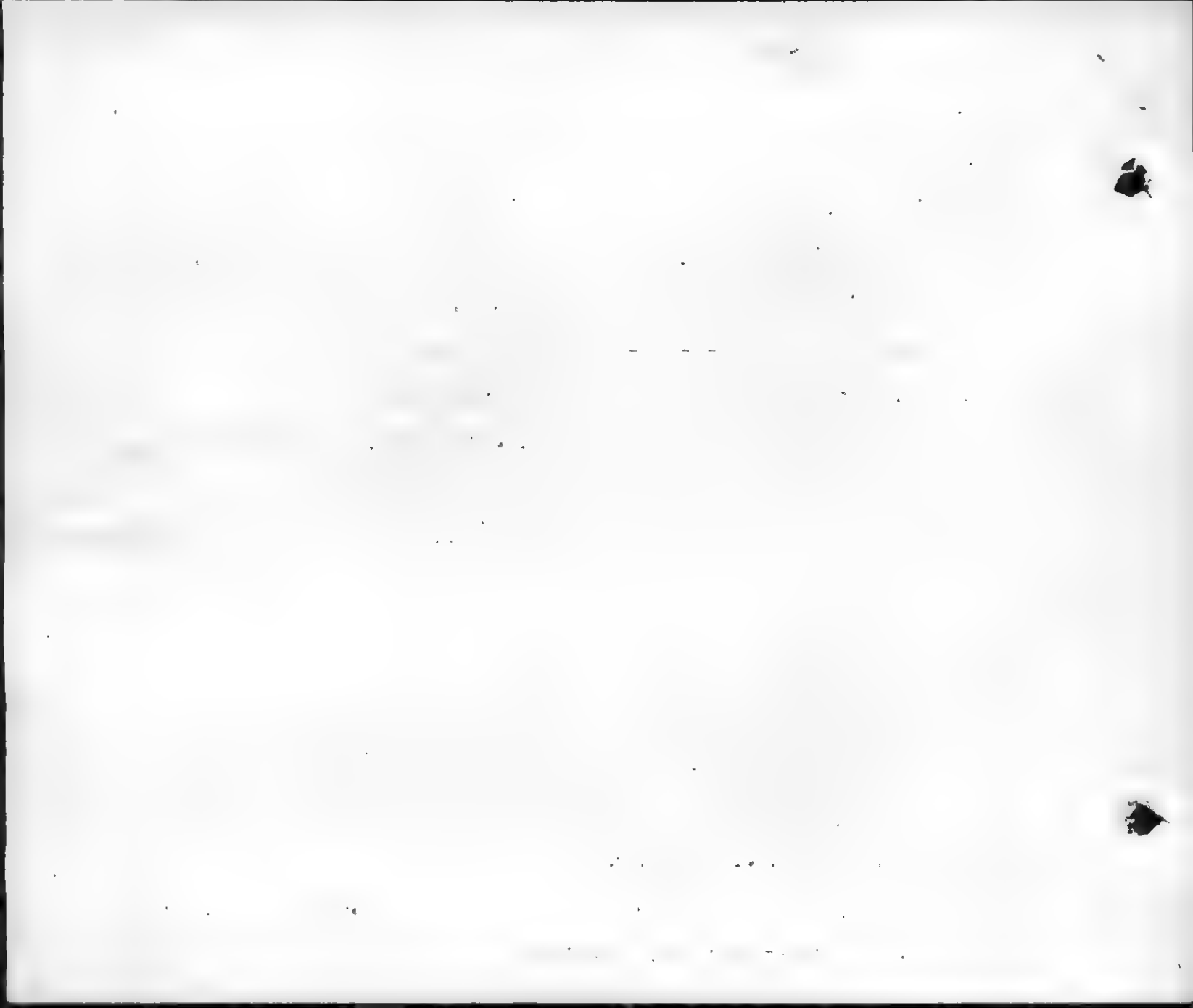
CERTIFICATE OF DEATH

Reg. Dist. No.

03375

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Ropin Rest Home		e. STREET ADDRESS 10915 Clermont Avenue	
3. NAME OF DECEASED (Type or print) GRACE R. STALEY		4. DATE OF DEATH March 26, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1879
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR 1 Months 13 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Jason S. Roberts		14. MOTHER'S MAIDEN NAME Maria Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruth Warring-Same Item #2-daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Central thrombosis DUE TO (b) Central arteriosclerosis DUE TO (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerotic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 1955 to March 26, 1959 that I last saw the deceased alive on March 25, 1959 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Seruch T. Kimble M.D.		ADDRESS (Street, city or town, state) 929 Frederick Ave, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Seruch T. Kimble, M. D.		DATE SIGNED 26 March 1959	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/28/1959	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03376

3389

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Quantico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 211 Broadway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charlie STEARMER				4. DATE OF DEATH Month Day Year March 3 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-1900	
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY - - - -			
13. FATHER'S NAME Henry W. STEARMER				14. MOTHER'S MAIDEN NAME Sarah HORTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 579-38-6675		17. INFORMANT Address (W) Mrs. Etta M. Stearmer, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection of Myocardium 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic atherosclerotic heart disease DUE TO (c) 2 yrs.						INTERVAL BETWEEN ONSET AND DEATH 4 days +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 23, 1959 to March 3, 1959 , that I last saw the deceased alive on March 2, 1959 , and that death occurred at 6:00A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 3-3-59							
ACTUAL SIGNATURE R. G. MUTH		M.D. U. S. Naval Hospital, NMMC					
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN		Bethesda 14, Maryland					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general public, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3390

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stella Harrell Stokes</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1874</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Markham, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>Markham, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edmund Harrell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ryan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Maxwell Stokes</u>	
17. ADDRESS <u>5412 35th St Washington, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Abdominal Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary site undetermined</u> (c) <u>3 Mos.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 10, 1958</u> to <u>March 8, 1959</u> that I last saw the deceased alive on <u>March 5, 1959</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Harrell</u>		DATE SIGNED <u>3-8-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Harrell</u>		ADDRESS (Street, city or town, state) <u>5516 Yeb. Ave. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manassas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Manassas, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

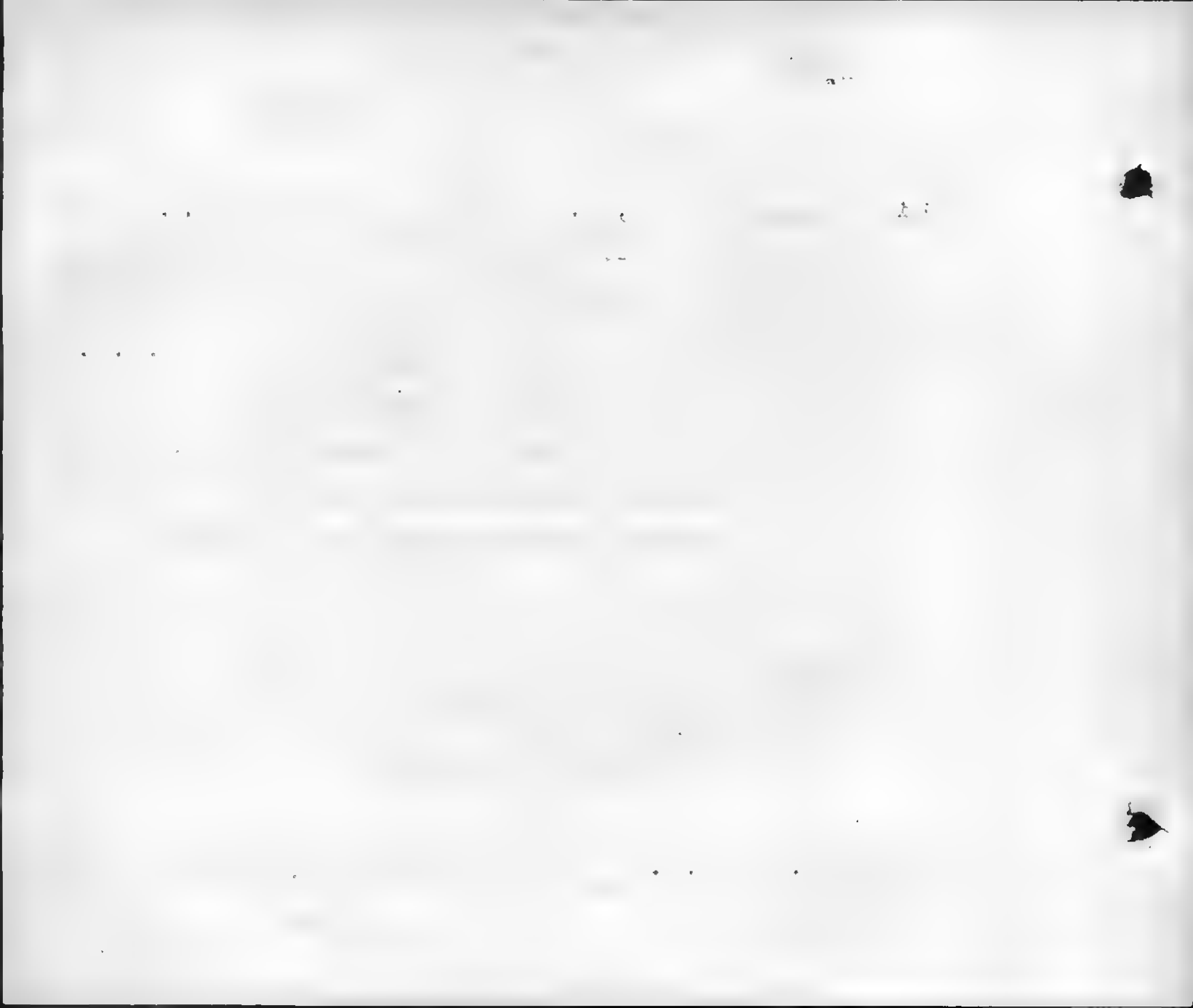
3391

CERTIFICATE OF DEATH

03378

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1625 Massachusetts Avenue, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Helen First Sutin Middle 0000 Last 0000		4. DATE OF DEATH Month March Day 9, Year 1959							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1892	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months 66	IF UNDER 24 HRS Days 66	Hours 66	Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ignatz Stern				14. MOTHER'S MAIDEN NAME Fannie Edleman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema associated with uremia 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of bladder with widespread metastases DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 11, 1959 to March 9, 1959 , that I last saw the deceased alive on March 9, 1959 , and that death occurred at 11:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 3/10/59 The National Institutes of Health Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) Falls Church Va.			
23. FUNERAL DIRECTOR'S SIGNATURE B. Langworthy & Son - 3501-14th St. N.W. ADDRESS				24a. REC'D BY REGISTRAR DATE MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



3392

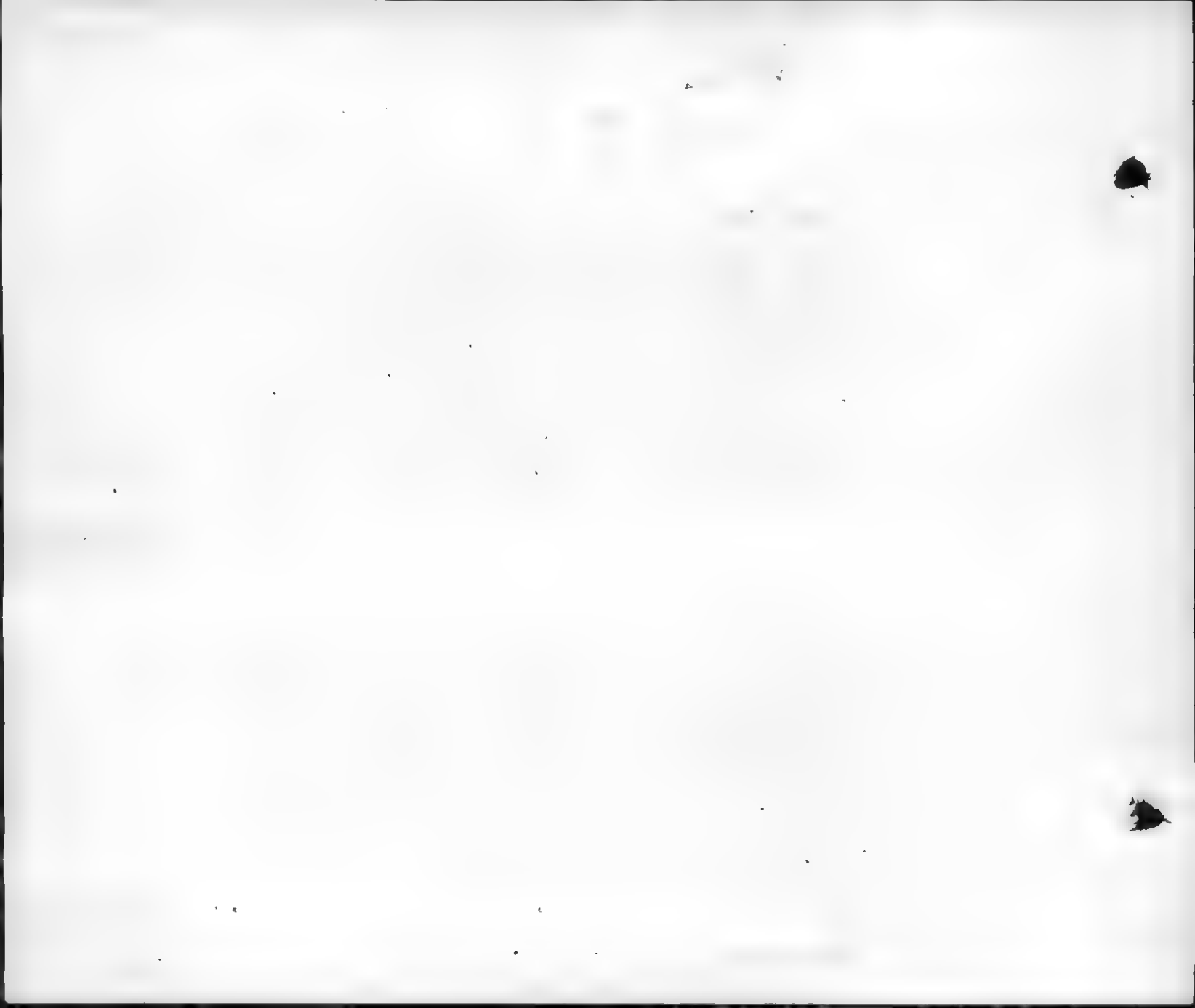
CERTIFICATE OF DEATH

Reg. Dist. No.

03379

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Montg. b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT ZION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RUSSELL NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERTA		Middle TOLBERT		Last TOLBERT		4. DATE OF DEATH Month 3/1/ Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Approx. 76 yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 22		16. SOCIAL SECURITY NO. 22		INFORMANT Melinda Rosewood Address Lawson Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carabral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis Primarily DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 12 hours Years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/59 to 3/1/59 , that I last saw the deceased alive on 2/2/59 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 3/1/59 ACTUAL SIGNATURE Jacob W. Bird M.D. Sandy Sperry PHYSICIAN'S NAME (Type) JACOB W. BIRD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/5/59		22c. NAME OF CEMETERY OR CREMATORY County Home,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3393

CERTIFICATE OF DEATH

Reg. Dist. No.

113340

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>4 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u> 47 X d. STREET ADDRESS <u>5218 CHEVYCHASE BLVD N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>GRALE</u> Middle <u>E.</u> Last <u>TOOLE</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1959</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-1885</u>		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>16</u> Hours _____ Min _____ IF UNDER 24 HRS: _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>E.W.M. COST</u>						14. MOTHER'S MAIDEN NAME <u>Alice L. CHREISSINGER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>MR. C. JAS. TOOLE</u>				Address <u>BETHESDA, MD. 8013 NEWDALE RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemopericardium (Cardiac tamponade)</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of heart</u> DUE TO _____ (c) <u>Acute Myocardial Infarction</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1-1/2 hr</u> <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)			
21. I certify that I attended the deceased from <u>9/1</u> , 19 <u>59</u> , to <u>3/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/8</u> , 19 <u>59</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 BATTERY LA</u> DATE SIGNED <u>3/9/59</u> ACTUAL SIGNATURE <u>Charles J. Savarise, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARISE, JR. BETHESDA, MD</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 10 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

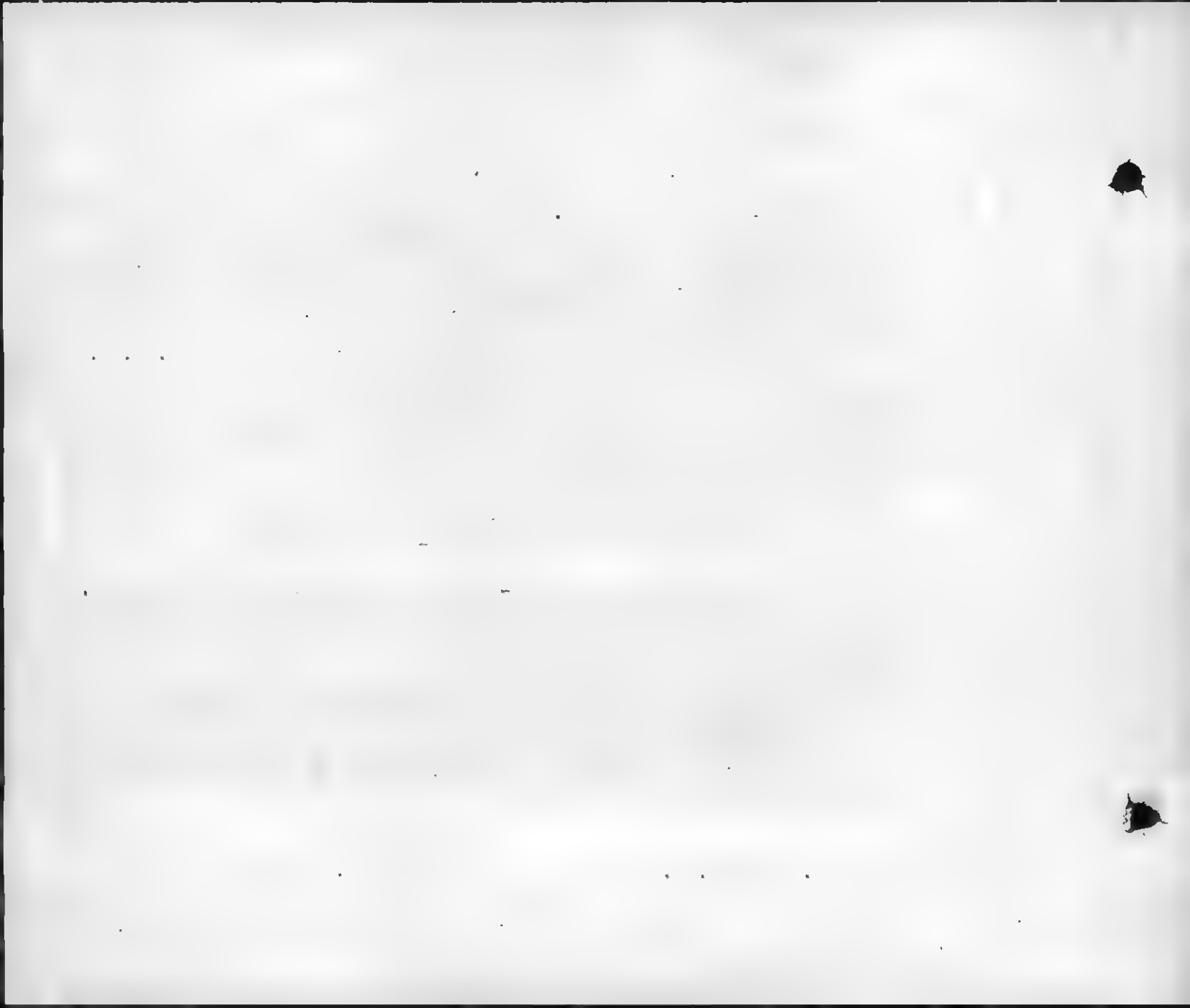
03381

3394

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 47 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived If institution, Res dence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4600 30th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Sylvester Last Townsend		4. DATE OF DEATH Month March Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government	9. AGE (In years last birthday) yrs 65 IF UNDER 1 YEAR: Months 10 Days 19 Hours 59 Min
11 BIRTHPLACE (State or foreign country) Massachusetts		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME John Henry Townsend		14. MOTHER'S MAIDEN NAME Hannah Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes (If yes, give year or date of service) WW I		16. SOCIAL SECURITY NO 032-01-6008	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) Necrotizing lobar pneumonia with abscesses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate gland- not metastatic DUE TO (c) Carcinoma of larynx - metastatic to cervical lymph nodes. PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 161X			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 22, 19 59 , to March 10, 19 59 , that I last saw the deceased alive on March 10, 19 59 , and that death occurred at 11:40 P. M. from the causes and on the date stated above			
ACTUAL SIGNATURE James A. Rose		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/11/59	
PHYSICIAN'S NAME (Type) James A. Rose, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/13/59	Arlington National Cemetery	Arlington, Va
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		24a. REC'D BY REGISTRAR Mt. Rainier Maryland	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



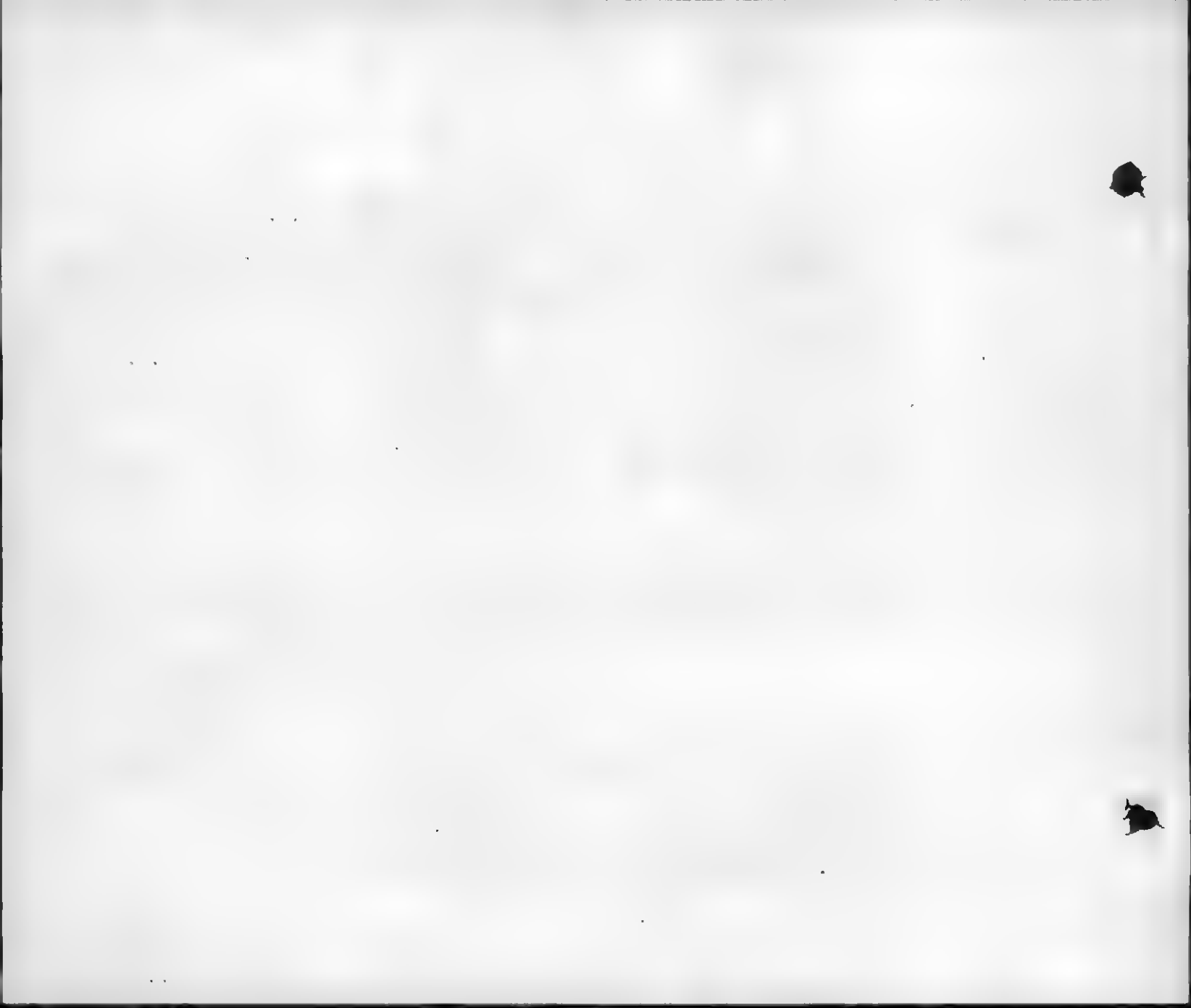
3395

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 208 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Roanoke c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke d. STREET ADDRESS 505 Gregory Ave., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Alton Last TYSON			4. DATE OF DEATH Month March Day 4 Year 1959				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-39	9. AGE (In years last birthday) 19 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months 4 Days 19 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY U.S.A.			13. FATHER'S NAME Rufus C. TYSON				
14. MOTHER'S MAIDEN NAME Eulalia BLAGMAS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 8/21/56 to DOD 233-58-7256				
16. SOCIAL SECURITY NO. 18/21/56 to DOD 233-58-7256			17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe acquired hemolytic anemia 272.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 272.2 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)		
21. I certify that I attended the deceased from August 8 , 19 58 , to March 4 , 19 59 , that I last saw the deceased alive on March 4 , 19 59 , and that death occurred at 6:00A M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 3-4-59							
ACTUAL SIGNATURE R. G. Galbraith, Jr.		M.D. U. S. Naval Hospital, NMMC					
PHYSICIAN'S NAME (Type) R. G. GALBRAITH, JR., LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-9-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Snowden Funeral Home, Rockville, Md.			24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Huns		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown b. COUNTY Unknown			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brighton				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brighton Dam				e. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Unknown				4. DATE OF DEATH Month Day Year Mar 21 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) new born		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? Unknown							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Montg. Co. Police		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure 983X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Found dead in trash can							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDIT ON GIVEN IN PART I (a) Baby found dead in trash can at brighton Dam, Brighton Md.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3/21/59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Found at Brighton Montg Md,	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/21/59	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24		22c. NAME OF CEMETERY OR CREMATORY Laytonsville, Meth.		22d. LOCATION (City, town, or county) (State) Laytonsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3397

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Virginia b COUNTY Arlington ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d STREET ADDRESS 2361 N. Quebec Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Hazel Middle Marie Last VANCE				4. DATE OF DEATH Month March Day 13 Year 1959			
5. SEX Female		6 COLOR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-20-88	
9 AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Iowa	
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WIDENER				14. MOTHER'S MAIDEN NAME Ella COONEY			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO. 562-18-9049		17 INFORMANT (D) Mrs. Shirley V. Lanham, same as #2 above	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage 301X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21. I certify that I attended the deceased from March 10 19 59 to March 13 19 59 , that I last saw the deceased alive on March 12 19 59 , and that death occurred at 3:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John Wood Davis				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NVMC			
DATE SIGNED 3-13-59							
PHYSICIAN'S NAME (Type) J. W. DAVIS LT MC USN				Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		3-25-59		Forest Lawn Memorial Park, Glendale, California			
23 FUNERAL DIRECTOR'S SIGNATURE J. Gawler's & Sons				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Jos. Gawler's & Sons, 1756 Pa. Ave., NW, Wash. DC				MAR 17 '59		Arthur S. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3246

CERTIFICATE OF DEATH

03385

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>34 Franklin St. N.E. Wash. D.C.</u> b COUNTY <u>Washington, D.C.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Roma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>Washington, D.C.</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven</u>		d STREET ADDRESS <u>517 Albany Ave. Tak. Pk.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>L.</u> Middle <u>Ward</u> Last		4. DATE OF DEATH <u>March 23</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5, 1879</u> 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>John Reid</u>		14 MOTHER'S MAIDEN NAME <u>Allison Bruce</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Annie R. Ward</u> Address <u>34 Franklin St. N.E.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis cerebral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Anteriorly</u> DUE TO (c) <u>Anteriorly</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1958</u> to <u>3-23</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3/23/59</u> , 19 <u>59</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.W. Smith</u> M.D. <u>13018 Georgia Ave</u>		DATE SIGNED <u>3-23-1959</u>	
PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3</u>	22b. DATE THEREOF <u>3-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Saweers Sons, Wash. D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3398

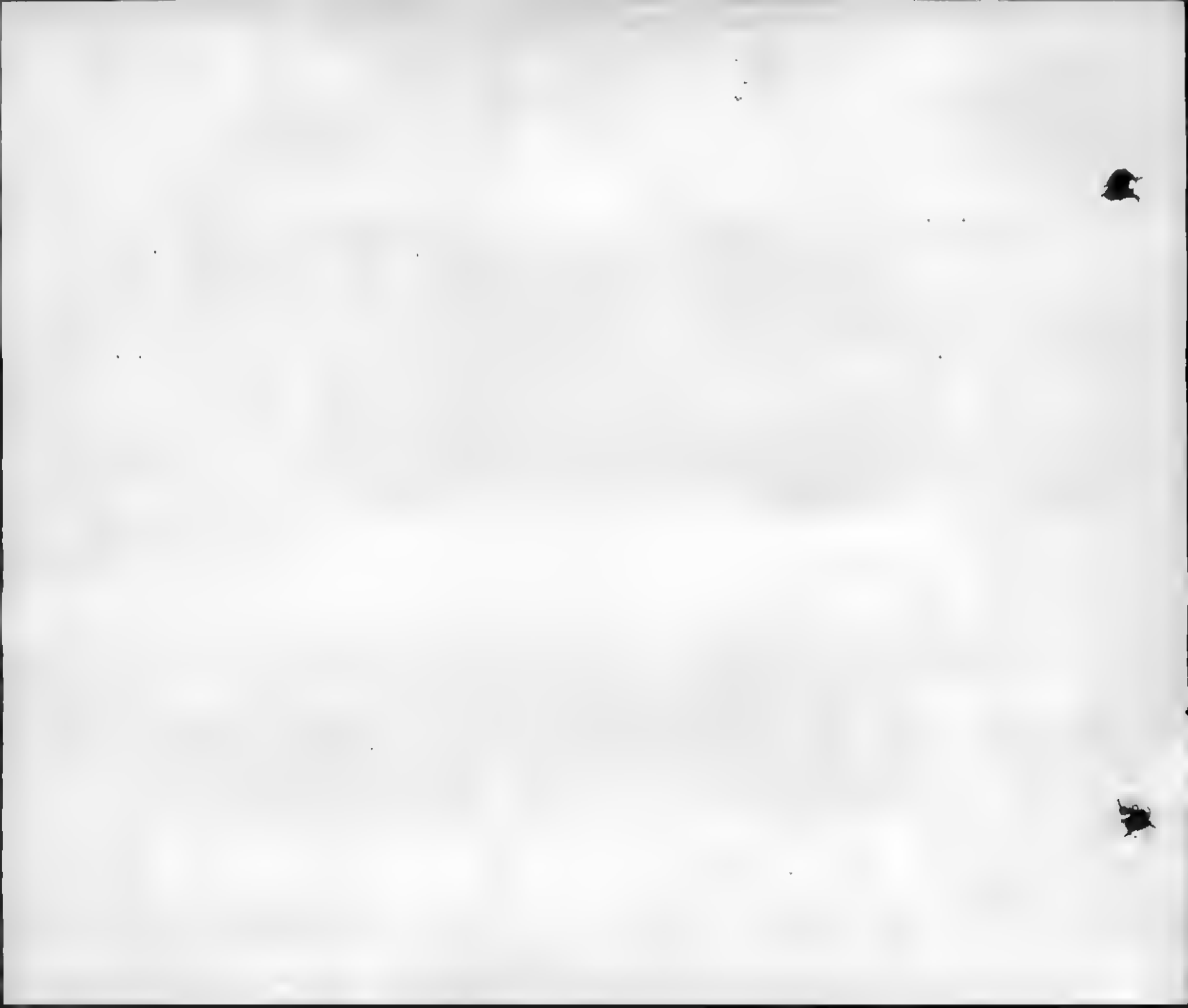
03386

Reg. Dist. No. 215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Queens			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Jamaica, Long Island			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 92-28 170th Street			
3. NAME OF DECEASED (Type or print) First Middle Last Fred (none) WATTS, JR.				4. DATE OF DEATH Month Day Year March 15 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-38	
9. AGE (In years and birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Fred WATTS				14. MOTHER'S MAIDEN NAME Lillie Mae (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 10-25-55 to DOD Unknown				16. SOCIAL SECURITY NO Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration							
24a DUE TO (b) fracture of skull							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Jumped from truck moving at appr. 20 MPH			
20c. TIME OF INJURY Month, Day, Year Hour am 3-6 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Key West Monroe Florida	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. BROSCART, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3-16-59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial Shipment		3-18-59		Long Island National Cem.		Farmingdale New York	
23. FUNERAL DIRECTOR'S SIGNATURE Adams				ADDRESS Adams Funeral Home, 4748 Wisc. Ave., NW, WASHDC		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanks							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3399

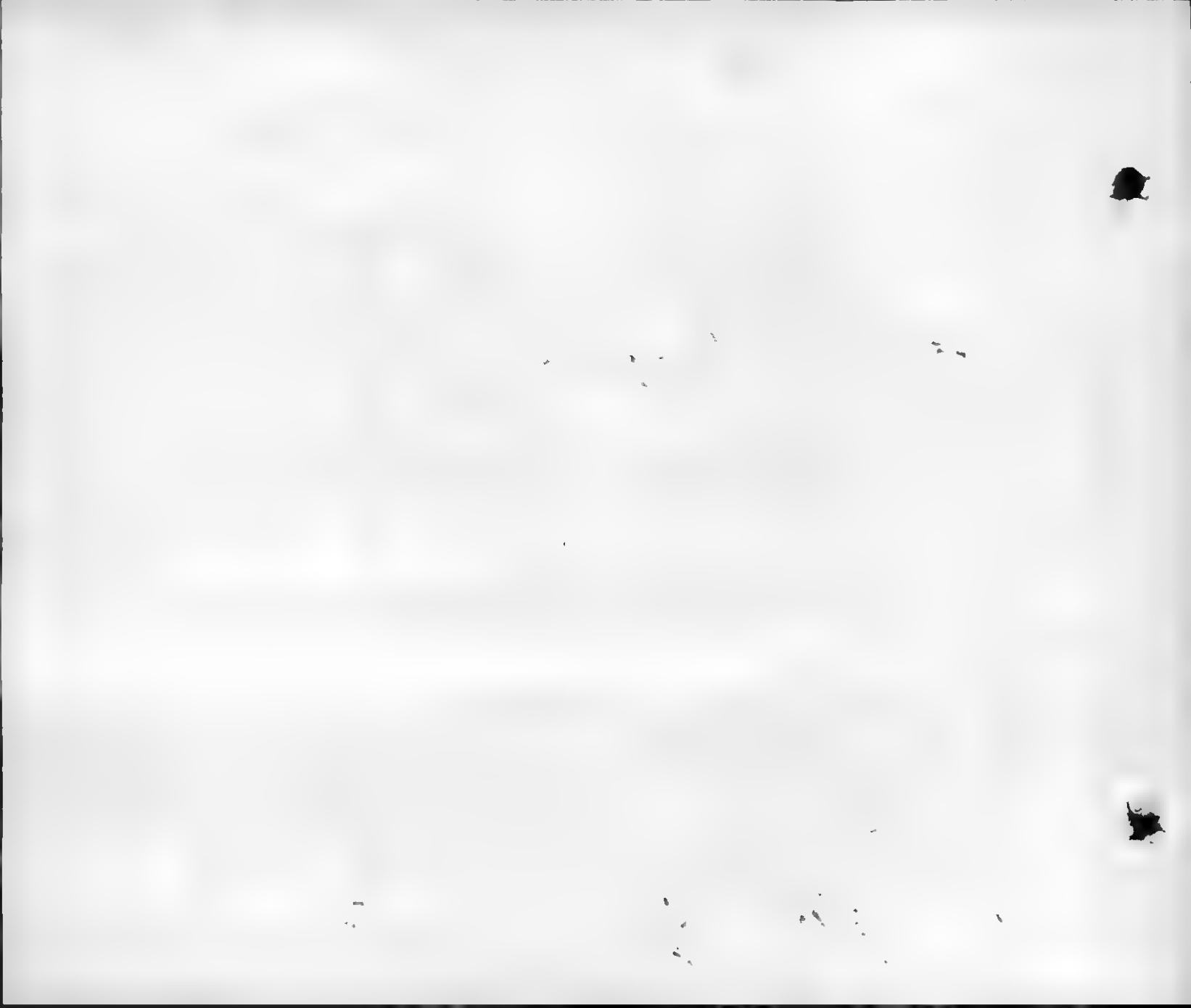
CERTIFICATE OF DEATH

03387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL d. STREET ADDRESS JOHNS HOPKINS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last VINCENT VERNON WEHLAND				4. DATE OF DEATH Month Day Year MARCH 15 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/27/85	
9. AGE (In years last birthday) 73 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Corn farm		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME HERMAN WEHLAND			
14. MOTHER'S MAIDEN NAME ELEANOR REED				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA AND DEHYDRATION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) VENTRICULAR TACHYCARDIA DUE TO (c) MYOCARDIAL INFARCT						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 1 WEEK 6 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25 1959 to 3/15 1959 , that I last saw the deceased alive on 3/15 1959 , and that death occurred at 11:15P M. from the causes and on the date stated above ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND DATE SIGNED 3/16/59							
ACTUAL SIGNATURE <i>[Signature]</i>		M. D. C. H. LIGON, M. D.					
PHYSICIAN'S NAME (Type)		SANDY SPRING, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/59		22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS Laurel, Md		24a. REC'D BY REGISTRAR DATE MAR 19 59	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3247 - CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitation</u>				d. STREET ADDRESS <u>9405 Caroline Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Charles</u> Last <u>Weissman</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Irish</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1916</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mgr dept store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NY</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN WEISSMAN</u>				14. MOTHER'S MAIDEN NAME <u>(UNK)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or date of service) <u>1 W.W.II</u>				16. SOCIAL SECURITY NO <u>107-16-7725</u>		17. INFORMANT <u>SATYA HELLER WEISSMAN</u> Address <u>4405 CAROLINE AVE SILVER SPRING MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 28, 1959</u> to <u>March 17, 1959</u> that I last saw the deceased alive on <u>March 16, 1959</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9310 Calverton Rd, Silver Spring, Md.</u> DATE SIGNED <u>3/17/59</u>							
ACTUAL SIGNATURE <u>Ledney Leavitt</u>				PHYSICIAN'S NAME (Type) <u>Ledney Leavitt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 19. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARL. NAT'L Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>ARL., VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Soldier's Union</u> ADDRESS <u>4217-9th Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3400

CERTIFICATE OF DEATH

Reg. Dist. No.

03383

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>...</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING MD.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8607 Cedar St.</u>		d. STREET ADDRESS <u>8607 CEDAR ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle <u>MARIE</u> Last <u>WENDELIN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 31 1871</u>
9. AGE (In years last birthday) yrs. <u>87</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ALAND EUROPE</u>		12. CITIZEN OF WHAT COUNTRY? <u>FINLAND</u>	
13. FATHER'S NAME <u>KARL WENDELIN SODELAND</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN PALMQUIST</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>YES</u>	
17. INFORMANT <u>KAREN SUOMELA</u>		Address <u>611 SUMMIT AVE. MONESSEN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6-7 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 27 1959</u> , to <u>March 9 1959</u> , that I last saw the deceased alive on <u>Feb 27 1959</u> , and that death occurred at <u>4 A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Ruff</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9006 Coleville Rd, Silver Spring, Md. 3/9/59</u>	
PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9 MAR 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Monessen, Penn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>		ADDRESS <u>816 HST. N.E. WASH DC</u>	
24a. REC'D BY REGISTRAR <u>MAR 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03390

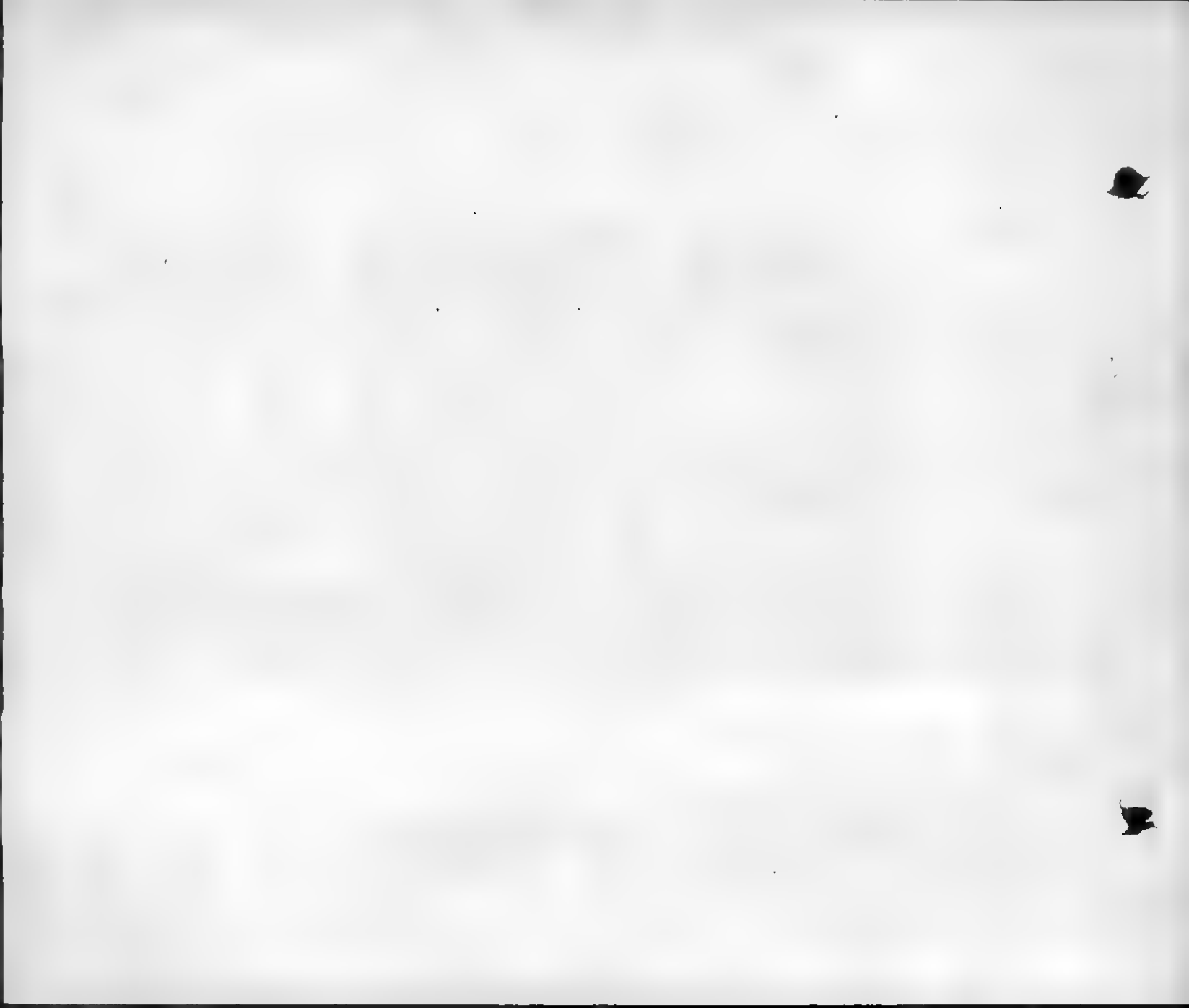
3401

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u>	
c. LENGTH OF STAY IN 1b <u>1 mo</u>		d. STREET ADDRESS <u>208 Park Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont Farm Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth C. Wilkinson</u>		4. DATE OF DEATH <u>Mar 9th 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-1906</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New Orleans La</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John N. Breen</u>		14. MOTHER'S MAIDEN NAME <u>Ann Demote</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nursing Home records</u>		Address <u>none</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bronchial Asthma</u> (c) <u>14 yrs</u> DUE TO (c) <u>14 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Arthritis 30 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>3-10-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner</u>		24a. REC'D BY REGISTRAR <u>MAR 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 104. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0339i

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Month.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 2 hrs.		d. STREET ADDRESS 308 Frederick Ave., Lincoln Pk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) April Mae Williams		4. DATE OF DEATH Month Mar. Day 22 Year 1959	
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/1958
9. AGE (In years last birthday) 5 yrs.		10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Dines		14. MOTHER'S MAIDEN NAME Lillian Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Lillian Williams (mother)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inhalation of smoke and fumes and 3rd degree burns involving head and upper extremities (c) upper extremities INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Sleeping in basement of burning home	
20c. TIME OF INJURY Month, Day, Year 8:02 a.m. 3/22/59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Rockville Montg. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/23/59	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/25/59	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral home. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03392

3403

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>308 Frederick Ave., Lincoln Pk.</u>	
3. NAME OF DECEASED (Type or print) <u>Helen Marie Williams</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/1955</u>
9. AGE (in years last birthday) <u>3</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Lillian Williams (mother)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Inhalation of smoke and fumes and 3rd Degree</u> burns involving head, body & extremities Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Sleeping in basement of burning home</u>	
20c. TIME OF INJURY Month, Day, Year <u>3/22/59</u> Hour <u>3:02</u> P. M. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Rockville Mont. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Supradine</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



3248

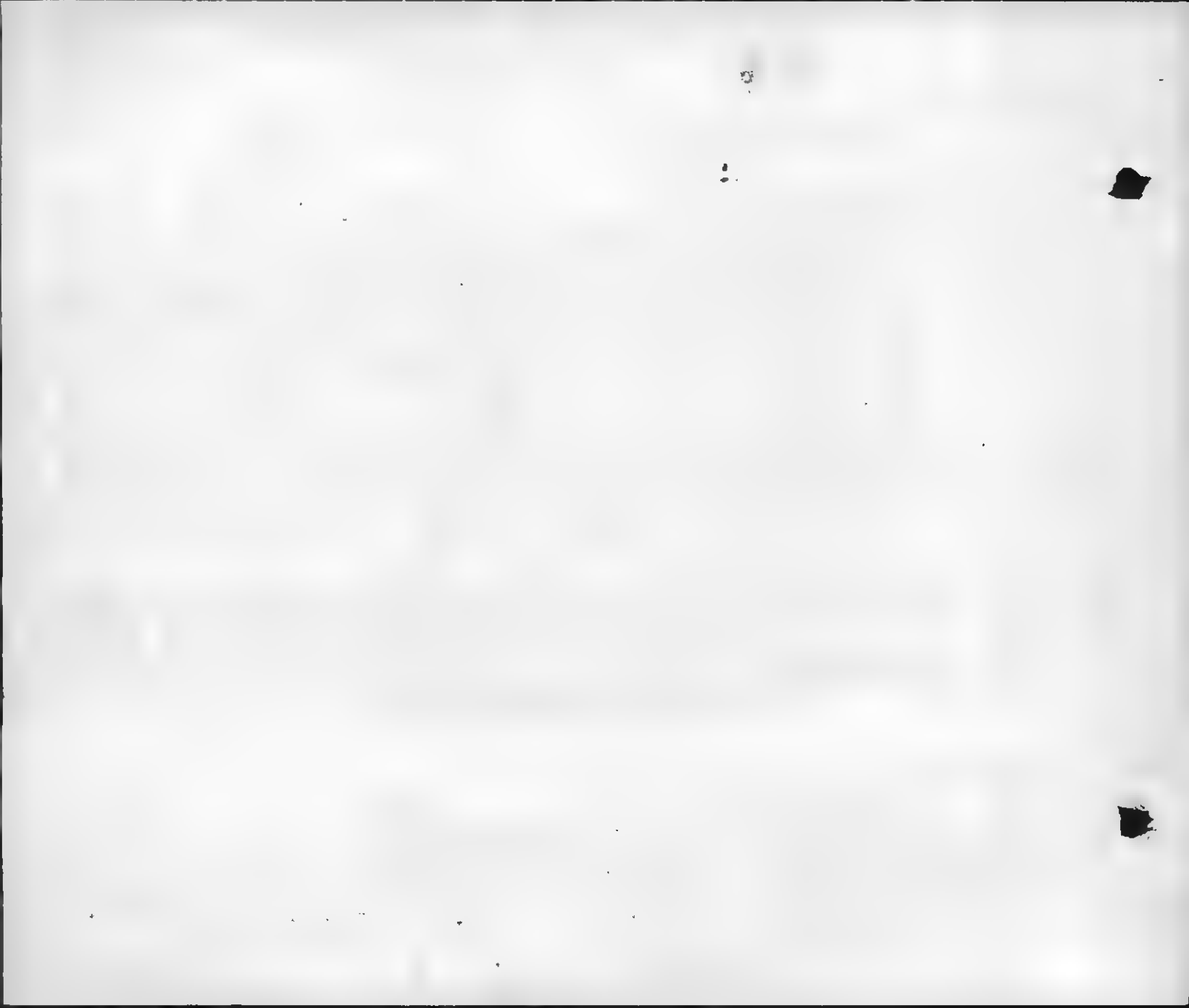
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. STREET ADDRESS <u>602 University Bldg. E</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Julia Windsor</u>				4. DATE OF DEATH <u>3-11-1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-95</u>	
9. AGE (In years last birthday) <u>60</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>				13. FATHER'S NAME <u>Middleton King</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Waters</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>034X Congestive Cardiac Failure</u>							<u>2 day</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis - Coronary</u>							<u>2 yrs.</u>
(c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/25, 1957</u> to <u>3/11, 1959</u> , that I last saw the deceased alive on <u>3/11, 1959</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville Park, Md.</u>			
DATE SIGNED <u>3/11/59</u>							
PHYSICIAN'S NAME (Type) <u>Robert H. Hare, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 13</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Glaggettville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

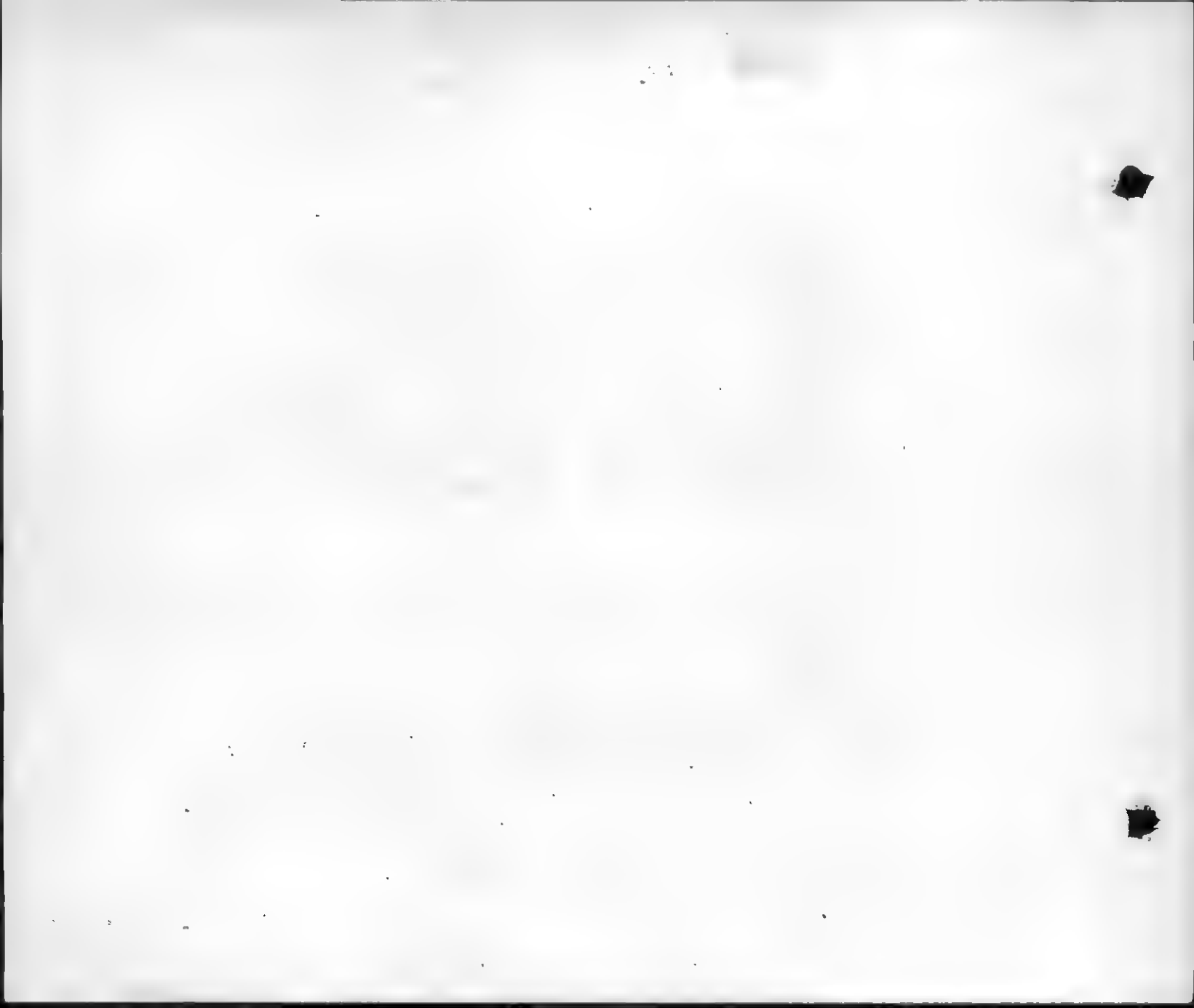
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03394

3249

VS A15 (4)
15M 9/50



CERTIFICATE OF DEATH

03395

Reg. Dist. No.

3404

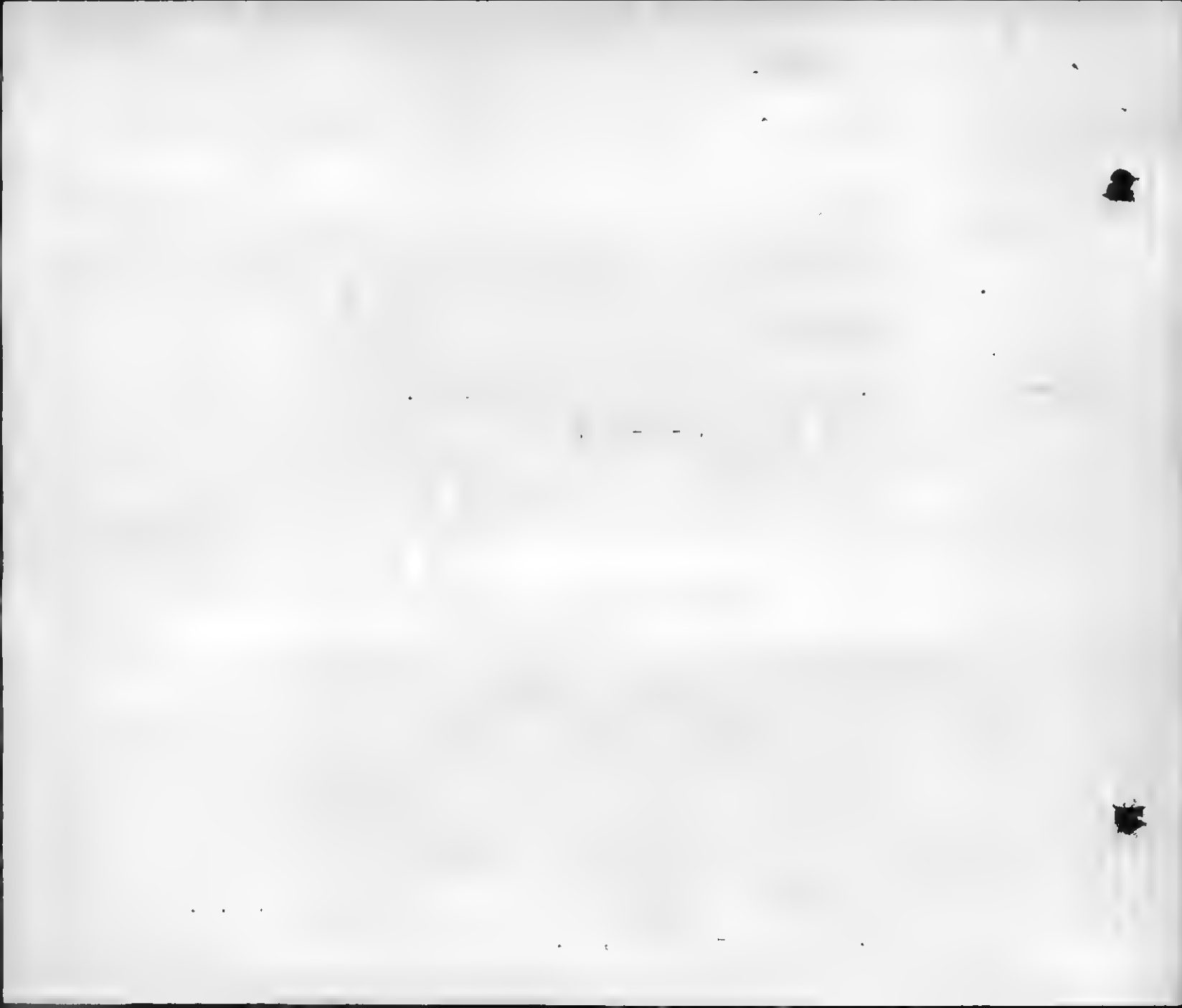
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>119 W. Kirke St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mallie Lou Walcott</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 27 1877</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>George A. Johns</u>				14. MOTHER'S M maiden name <u>Margaret L. Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO <u>578-46-7962</u>		17. INFORMANT <u>Daughter, Karen Boyd Walcott</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332x Infarction, right basal ganglia brain</u>						<u>6 days</u>	
DUE TO (b) <u>Thrombosis, right internal carotid artery</u>						<u>6 days</u>	
DUE TO (c) <u>Atherosclerosis, moderate</u>						<u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1949</u> , to <u>March 6</u> , 1959, that I last saw the deceased alive on <u>March 6</u> , 1959, and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>3921 Ingomar St NW</u>		<u>3-7-59</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				<u>Wash 15 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Throckm</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3405

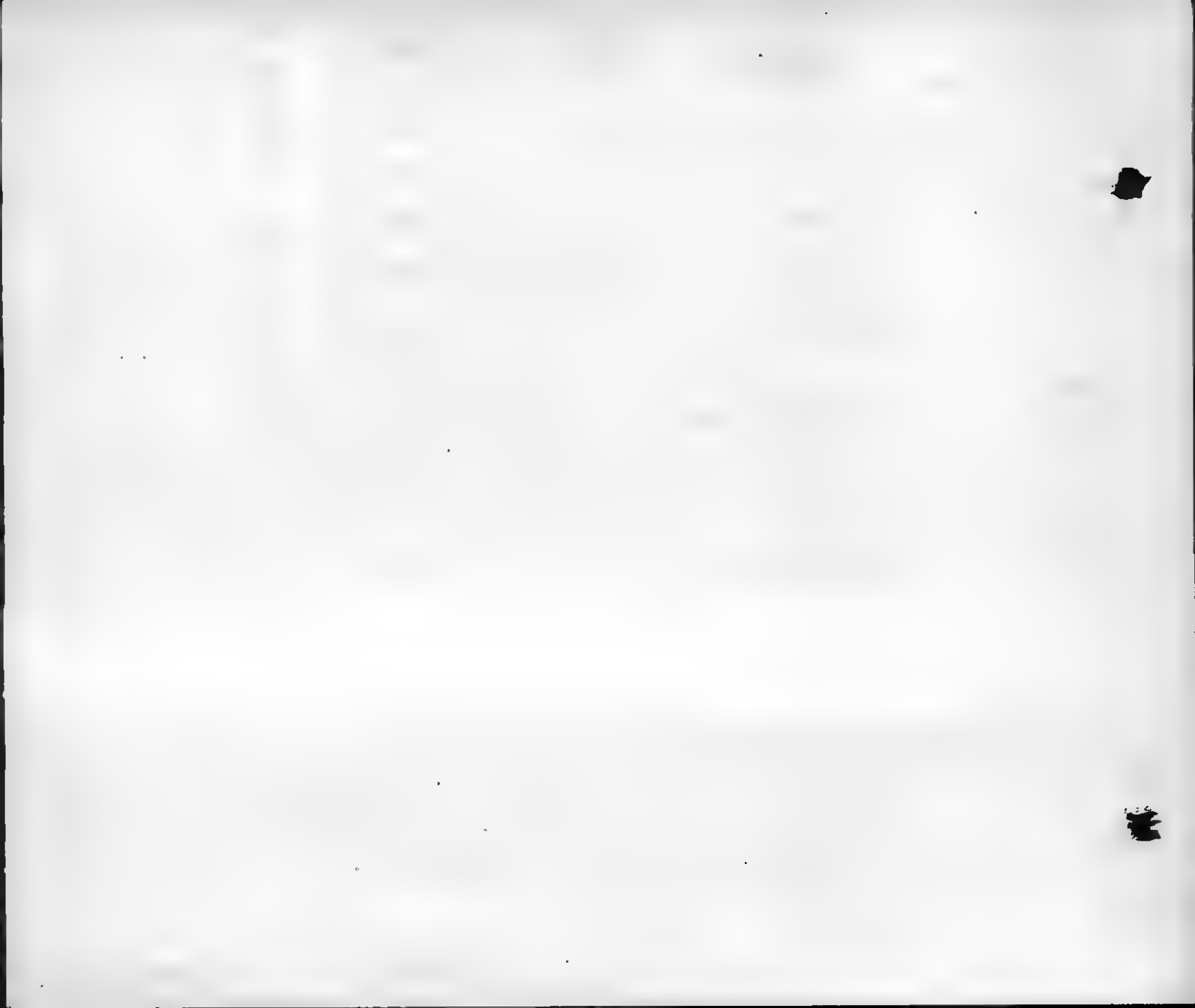
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jennifer Lynn WOOD				4. DATE OF DEATH Month Day Year March 24 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-58	
9. AGE (In years last birthday) yrs 4		10. IF UNDER 1 YEAR Months 4		11. IF UNDER 24 HRS Days 6		12. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Dale Clifford WOOD				14. MOTHER'S MAIDEN NAME Laurie Myrtilia DAVIES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) Dale C. Wood, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Stagnant blood pressure</i> DUE TO (c) <i>Plural effusion</i>							INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>small amount of blood clot - medical problem</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from March 20, 1959, to March 24, 1959, that I last saw the deceased alive on March 24, 1959, and that death occurred at 4:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Kenneth W. Sell</i>				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 3-25-59	
PHYSICIAN'S NAME (Type) Kenneth W. SELL, LT, MC, USN Bethesda, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-59		22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Darnestown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gartner Funeral Home, Gaithersburg, Md.				24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3250

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. Hosp.</u>				d. STREET ADDRESS <u>8414 12th Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Neil Allen Woodcock</u>				4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-54</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>3</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Carlton Woodcock</u>				14. MOTHER'S MAIDEN NAME <u>Annadelle Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Carlton Woodcock</u> Address <u>(Father)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> DUE TO (b) <u>Cerebral-Palsy Severe.</u> DUE TO (c) <u>Encephalitis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>a.m.</u> p.m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>9/27/54</u> 19 <u>54</u> to <u>Present</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2/24</u> 19 <u>59</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8418 NH. Ave S.S., Md.</u>				DATE SIGNED <u>3/5/59</u>			
ACTUAL SIGNATURE <u>Warren G. Preisser</u>				M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>WARREN G. PREISSER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 5. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH., D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Latamuel</u> ADDRESS <u>3603 14th St NW</u>				24a. REC'D BY REGISTRAR <u>MAR 4 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Preisser</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03398

3406

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenixville 75x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, 14, Md.				d. STREET ADDRESS 120 3rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Allison Last Yeager				4. DATE OF DEATH Month March Day 1 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1889			
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Professor		10b. KIND OF BUSINESS OR INDUSTRY Education			
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Allison E. Yeager					
14. MOTHER'S MAIDEN NAME Clara E. Beerbower				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					
16. SOCIAL SECURITY NO. 181-26-2069				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from February 5, 1959 to March 1, 1959 , that I last saw the deceased alive on March 1, 1959 , and that death occurred at 5:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-2-59 ACTUAL SIGNATURE Edgar H. Levin M.D. National Institutes of Health Bethesda 14, Maryland									
PHYSICIAN'S NAME (Type) Edgar H. Levin M. D.									
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		March 5, 1959		St. Vincent Cemetery		Chesapeake Co. - Panna.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur Keller				ADDRESS 254 Carroll St. N.E.		24. REC'D BY REGISTRAR DATE MAR 3 '59			
25. REGISTRAR'S SIGNATURE Arthur L. Kraus									

CERTIFICATE OF DEATH

3408

5-6-57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03399

Reg. Dist. No.

3251

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sen + Hosp.</u>		e. STREET ADDRESS <u>1810 Arcado Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Theodore Young</u>		4. DATE OF DEATH <u>Mar 28 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-28-06</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>real estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>358 09 0823</u>	
17. INFORMANT <u>Kenneth V. Young</u>		Address <u>4313 Mahan Rd Wheaton md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wounds in lower left chest</u> (c) <u>stating the underlying cause first.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wounds (2) in lower left chest</u>	
20c. TIME OF INJURY Month, Day, Year <u>Mar 28 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u>		20f. (City or town) <u>Silver Spring Montg md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>APR 1 '59</u>		DATE <u>3-28-59</u>	
24b. REGISTRAR'S SIGNATURE <u>Orlino S. Finner</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

